# HIV Prevention and Injection Drug Use in Maine

A Statewide Needs Assessment

HIV/STD Program
Division of Disease Control
Bureau of Health
Department of Human Services
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# Introduction

Since the emergence of AIDS in the United States over two decades ago, injection drug use (IDU) has increasingly played a major role in the spread of HIV, the virus that causes AIDS. IDU has also been an important factor in the spread of hepatitis C virus (HCV). One third of all AIDS cases and over half of all HCV cases are IDU-related. Injection drug users (IDUs) risk blood-borne infections, like HIV and HCV, through sharing syringes, drug preparation and injection equipment[1], and drugs that have been contaminated with HIV and/or HCV-infected blood.

According to the Maine Bureau of Health, sharing needles and works among IDUs is the second most frequently reported way that HIV is transmitted in Maine, after male-to-male sexual (MSM) transmission. During the period 1997 through 2001, IDUs who shared needles comprised between 13 percent and 21 percent of annual HIV diagnoses and 10 percent to 37 percent of annual AIDS diagnoses in Maine. Among IDUs living with diagnosed HIV reported through 2001, 87 percent were white, 6 percent were black, and 6 percent were Hispanic or Latino. Most individuals (51 percent) received their diagnosis between the ages of 30 and 39 years. While cases of IDU-related HIV have been reported in every county in Maine, the largest proportion (50 percent) of IDUs living with diagnosed HIV lived in the southern area of Maine, including Cumberland and York counties, at the time of their diagnosis. Thirty-two percent lived in the central area of Maine, including Androscoggin, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, and Waldo counties. Seventeen percent lived in the northern area of Maine, including Aroostook, Hancock, Penobscot, Piscataquis, and Washington counties.

The increasing trend of HIV infection by IDUs reported nationally, the major role that IDU plays in the Maine HIV epidemic, and increasing media reports and anecdotal information about the rise of IDU in Maine have lent urgency to the need for having relevant information to plan prevention activities. There are no existing data sources to readily determine the number of IDUs in Maine or assess their demographic characteristics. Information is currently needed to examine the scope of IDU in Maine and to identify the prevention needs among IDUs who share needles and works in order to plan and deliver effective and appropriate prevention interventions. Prior to this report, there has been no statewide assessment of the HIV or HCV prevention needs of IDUs.

## Purpose

This report is an assessment of the HIV prevention needs of IDUs in Maine. The purpose of this assessment is twofold. First, it attempts to describe the scope of IDU in Maine using existing sources of data. How much IDU is happening in Maine? What areas in Maine are most affected? What are the IDU trends?

[1] Drug preparation and injection equipment is referred to as "works." Works include a spoon or some type of cooker, water or other fluid, and cotton or other absorbent material. Throughout this report, it should be understood that the risk for HIV and other blood-borne infection is through the sharing of needles and works that have been contaminated with infected blood.

Second, this needs assessment attempts to identify the HIV prevention needs of IDUs in Maine using information from interviews with service providers for IDUs as well as from current and former IDUs. For the purpose of this assessment, HIV prevention needs are defined as skills, behaviors, attitudes, knowledge, and access to services and devices that are necessary for IDUs to reduce their risk of HIV infection. Findings from this needs assessment can be used by organizations and individuals working in the IDU field to identify the unmet HIV prevention needs of IDUs in their community and develop effective and appropriate HIV prevention interventions to address those needs. While this is primarily an assessment of HIV prevention needs, the findings are also relevant for HCV prevention because both diseases are blood-borne and infection occurs through contact with infected blood by sharing needles and works.

Throughout this report, only blood-borne HIV infection among IDUs is addressed. The practice of sharing needles and/or works with other injectors is the single most common way IDUs become infected. IDUs are also at risk for HIV infection through other transmission routes. IDUs can be infected through semen and vaginal secretions during sex, and female IDUs risk transmitting HIV to their babies during delivery. The effects of drugs may influence the user's decisions and actions regarding sexual behavior, thereby contributing to the risk. This assessment only addresses IDU-related blood-borne disease risk; it does not address sexual and perinatal risks among IDUs.

## Prevention Services Related to HIV Prevention Among IDUs

Maine has taken several steps to improve HIV prevention services that respond to blood-borne infection. Critical to these efforts has been increasing public access to sterile syringes to prevent the transmission of HIV and other blood-borne diseases. In 1993, Public Law 394 removed the prescription requirement for syringe sales, making it legal for individuals to buy syringes without a prescription in Maine.

In 1997, legislation was passed legalizing syringe exchange and amending the Maine drug paraphernalia law to legalize possession of up to 10 syringes. Syringe exchange programs, resulting from this law, known as needle exchange programs, require a "one-for-one exchange"; that is, a program must receive one used syringe for every new syringe it provides to program participants. A participant must obtain the initial syringe from a source other than the needle exchange program. Pharmacies are the only legal source of "starter" syringes.

In 1999, the Maine Pharmacy Association clarified its position on the laws concerning the sale of syringes. They ruled to support full implementation of the syringe laws for legitimate public and individual health reasons. The ruling unanimously endorsed the implementation of the laws as being "wholly consistent with the highest principles of pharmacy." The ruling stated that any pharmacist refusing to sell syringes must be ready to "justify that decision in light of both the statute's (32MRSA) broad sweep and its statutory intent."

As of March 2003, the Maine Bureau of Health has certified three organizations to establish and maintain needle exchange programs. These needle exchange programs are operated by the following organizations: Portland Public Health located in Portland, Eastern Maine AIDS Network in Bangor, and Down East AIDS Network in Ellsworth. The Portland Public Health needle exchange program has been operational since 1998.

The Eastern Maine AIDS Network began operating needle exchange in 2002. The Down East AIDS Network needle exchange program remains unfunded as of the writing of this report. Federal law prohibits the use of federal funds for the purpose of needle exchange, which has hampered the implementation of this important prevention service.

A variety of HIV prevention activities addressing blood-borne infection risk among IDUs have been in operation at the local community level over the past decade. The State of Maine Comprehensive HIV Prevention Plan, Update May 2002, identified people who share needles as the second most important population for receiving HIV prevention services. During 2001 and 2002, approximately $116,000 of federal HIV prevention dollars was awarded annually to community-based organizations in Maine to provide HIV prevention interventions to people who share needles. Interventions were aimed at changing attitudes, skills, knowledge, and behaviors that reduce the risk of HIV transmission among IDUs.

## Substance Abuse Treatment Services in Maine

There are alcohol and other drug abuse treatment centers in all of Maine's 16 counties. The types of services provided and the populations served by these centers vary. Outpatient therapy services, psychological evaluation, medication, and case management are typically available. Eleven counties have treatment centers that offer dual diagnosis (psychiatric and substance abuse) services. Hancock, Lincoln, Piscataquis, Waldo, and Washington counties do not have dual diagnosis services available locally.

There are eight detoxification (detox) centers, mainly located in hospital settings. There are three detox centers in Cumberland County, two in Kennebec County, and one each in Androscoggin, Knox, and Penobscot counties. In addition, Maine has four methadone treatment facilities: two in Cumberland County, one in Kennebec County, and one in Penobscot County. The methadone maintenance treatment programs provide outpatient services for those addicted to opiates, such as heroin, by offering methadone in combination with counseling. In monitored doses, methadone – a synthetic opiate – blocks the euphoric "rush" caused by heroin and other opiates while stabilizing the patient and avoiding the immobilizing effects of withdrawal.

## Maine Socio-Demographic Characteristics

Maine is a geographically large state. It is relatively poor, sparsely populated and rural in nature. According to the 2000 US Census, 1,274,923 people reside in the 16 counties of Maine (see County Map of Maine, Appendix A). Approximately 55 percent of Maine's residents live in rural communities, compared with 25 percent of the US population as a whole. Approximately one third of the population lives in one of the three major population areas of Portland, Lewiston/Auburn, and Bangor. Portland is the largest city in Maine. Thirty-six percent of the population lives in the southern part of the state in York and Cumberland counties.

Less than 4 percent of Maine's residents are non-white or Hispanic, compared to almost 18 percent for the US as a whole. The 2000 US Census estimates that of Maine's approximately 1.3 million residents, 0.7 percent are Hispanic, 0.7 percent are Asian or Pacific Islander, 0.5 percent are African-American/black, 0.5 percent are American Indian/Alaskan Native, and 0.9 percent are two or more races.

As of 1998, 10.7 percent of Maine residents were living below the poverty line, compared to 13.3 percent for the country as a whole. At the same time, reported per capita income ($19,590) compares poorly to the US reported per capita income ($22,713). The 1990 US Census indicates that among families with young children headed by women, poverty rates are significantly higher in Maine (63 percent) than for the US (57 percent).

## Methods – The Way this Needs Assessment was Done

Information for this needs assessment came from both quantitative and qualitative data sources. Existing quantitative data sources were used to identify the scope of IDU in Maine. Qualitative data sources, specifically developed for this assessment, were used to assess the HIV prevention needs of the injection drug using population.

In initiating this assessment, the researchers found there was no existing data source that reports the number of IDUs and their demographic characteristics in Maine. Estimates of IDU in Maine have been made, but these estimates rely on national data and formulas and their usefulness is questionable. There are also no systematic attempts underway to capture data about IDU that would give an accurate picture of the scope of IDU in Maine and the HIV prevention needs of IDUs.

This assessment collected two general types of information. First, data that were already gathered for other purposes were examined. A model developed by Patricia Case of Harvard University was used to approximate the scope of IDU in Maine through existing data sources that were likely to provide some information about IDU. The rationale for this approach is that, given the absence of an IDU surveillance system in Maine, existing data sources may capture some measure of IDU, even though that is not the primary purpose of the data source. Looking at these existing data sources can help shed some light on the scope of the IDU problem.

For this assessment, a variety of potential sources of existing data were researched. Data sources judged to provide information about the scope and demographic characteristics of IDU in Maine were selected. For example, data gathered on people who injected drugs and had received substance abuse treatment services were examined. These data describe a subset of IDUs – those who received treatment services. Other data sources gathered information by type or category of drug used, such as heroin, but not the method of drug use (injecting, snorting, ingesting).

Nine existing data sources were selected as indicators for this assessment. One of the sources, 2000 US Census data, was used to describe the demographic and socioeconomic profile of the population in Maine and to calculate case rates for the IDU indicators by county.

Three of the data sources were used to describe the impact of IDU on health. For the purpose of this needs assessment, these are called health impact indicators. HIV and AIDS morbidity data from 1996 to 2000 and HCV morbidity data from 1997 to 1999 provided information about the number of new cases of these blood-borne diseases transmitted through sharing contaminated needles and works by IDUs, as reported to the Maine Bureau of Health.

Morbidity data used for this report were:

1. HIV diagnoses among IDUs and males with the dual transmission mode of male-to-male sex and needle sharing (MSM/IDU)
2. AIDS diagnoses among IDUs and MSM/IDU
3. HCV infection among IDUs

Five of the data sources were used to describe the impact of IDU on social and criminal justice services. For the purpose of this needs assessment, these are called social impact indicators. These indicators were considered approximate measures for IDU because they collected information about some subset of IDUs or about a subset of people who used drugs that could be injected. The following data sources were used for this report:

1. Substance Abuse Treatment Data System statistics from 1996 to 2000 describe the subset of IDUs who received substance abuse treatment services at treatment sites throughout the state. Data used for this report were the number of people admitted to substance abuse treatment services who had injected drugs within the previous six months of admission.
2. Hospital Discharge data from 1996 to 2000 describe the subset of people using drugs that could be injected who received hospital services. Data used for this report were hospital discharge records from Maine hospitals with any mention of drug dependence involving continuous or episodic use of opium and its derivatives.
3. Maine Death Certificate data from 1996 to 2000 describe the subset of people who had a drug in their body that could be injected and was a cause or contributor to their death. Data used for this report were Maine death certificate reports involving heroin, methadone, and other related opioids as a cause or contributor to an individual's death.
4. Northern New England Poison Center data from1996 to 2000 describe the subset of IDUs in Maine counties who received poison control services. Data used for this report were calls to the statewide toll-free number that involved the misuse and overuse of injected drugs.
5. Maine Drug Enforcement Agency Arrest data from 1998 to 2000 describe the subset of people using drugs that could be injected who were arrested. Data for this report were the number of arrests related to heroin.

The second type of information used in this assessment was gathered directly from individuals with relevant IDU experience. Current and former IDUs as well as service providers who work with IDUs were interviewed individually and in groups, using questions developed for this assessment. Interviews of IDUs included two group interviews in addition to individual interviews, also conducted in 2001. Interviews of providers included individual interviews and five key informant interviews conducted in 2001. These data provide qualitative information about the HIV prevention needs of IDUs. See Appendix B for the questionnaires used to gather this information.

All data for this needs assessment were obtained through targeted surveillance systems or nonrandom, convenience sampling. For the existing quantitative data sources, the samples were based on information collected for a purpose other than estimating IDU and

were subsets of the IDU population (i.e., the number of IDUs admitted to substance abuse treatment services); they were not created to be representational of all IDUs. For the interview data, the samples were based on the convenience of who was contacted and who agreed to participate. The sample of IDUs was created by those IDUs who responded to providers' requests to participate in the study. The sample was not created to be representational of all IDUs. Nonrandom sampling provides an estimate of IDU and IDU needs of uncertain accuracy, which means the findings must be viewed cautiously.

# PART ONE – Quantitative Data

There is no single data source in Maine that provides information regarding the number of IDUs in the state and their demographic characteristics. Traditional survey methods and other data collection techniques have limitations because of the illegal nature of IDU and the related social stigma. However, general estimates of drug-using behaviors, drug-use environments, affected populations, and local trends can be made by examining data from applicable sources. This needs assessment examines data collected by state and local agencies and institutions that interact with IDUs in diverse situations. Collectively, these data serve to indicate the impact of IDU on Maine counties.

## General Data Limitations and Considerations

As a rule, the time period 1996–2000 was examined. This time span provides a general sense of drug-use trends or patterns that may have occurred during the period under consideration. Not all data were available for this time period. The data that most closely matched this five-year span were used when the reporting periods did not precisely correspond.

Generally, the data are presented at a county level. This allows for a better understanding of the geographic distribution of selected indicators. (See the county map of Maine in Appendix A for an illustration of Maine's county boundaries.) The primary data tables for each data source include rates per 100,000 population for the various indicators. The inclusion of rates, calculated using year 2000 Census figures, makes it possible to see the number of cases (or other data elements) proportional to a county's population size. It also allows for a comparison of rates between counties and with the statewide total. Examining cumulative totals for the data over a period of time helps to correct for outliers or single events that may skew that data for one particular year. The tables present the data in rank order, highlighting the statewide figures. When available, the data are presented in yearly totals as well as five-year cumulative totals to examine trends.

When possible, demographic breakdowns for the data – race, age, and gender – are provided. Since multiple data sources were utilized, there were variations in how the data were collected and compiled. Classifications of race/ethnicity, age range definitions, and categorization of drug types varied from one data source to another. (See Appendix B for drug names and classifications.) As a result, it is not possible to draw conclusions from one data source to another. In all cases, the data tables reflect the terminology used by the data source. In some cases (especially regarding race/ethnicity), the numbers are too small to make conclusive statements. None of the data have been tested for statistical significance.

This is a preliminary attempt to gather information and make an estimation of the public health risk of IDU. The intent of presenting quantitative data in this document is to offer a suggestion of the impact IDU is having on existing agencies in the state of Maine. The information comes from reliable institutions working to address the public health of Maine communities. Without a standardized statewide reporting system, however, there will be distinct limitations to fully understanding the IDU problem in this state.

## Maine Bureau of Health Disease Report Data

IDU is a primary transmission route for many blood-borne diseases. This needs assessment looks at three blood-borne diseases in attempt to provide a partial picture of the potential health impact of IDU in the state of Maine. Communicable disease reporting rules for the state of Maine require health professionals to report all hepatitis C (HCV), HIV, and AIDS diagnoses to the Bureau of Health. Reports include information regarding age, sex, and race of the individual, as well as place of residence at the time of diagnosis, and transmission risk factors. AIDS and HIV data have been collected since 1982 and 1987 respectively, but official case reporting for hepatitis C was only initiated in 1997. Due to the relatively new surveillance system for HCV, there are numerous variations in the data collected. In the hepatitis C data utilized for this report, the county totals will not match the totals for race, gender, and age due to incomplete survey results. Data were only available for the three-year period 1997–1999. Data used for this report include disease diagnoses in which IDU was identified as a risk factor. For HIV and AIDS diagnoses this includes diagnoses among IDUs and males with the dual transmission mode of male-to-male sex and needle sharing (MSM/IDU).

There are limitations to the disease report data. There are individuals who are infected with HIV, AIDS, and HCV who do not enter the health care system and therefore are not represented in the surveillance data. The rates of infection are very likely influenced by differences in the rates of testing from one county to another. Also, many IDUs may not disclose their transmission risk to physicians or health care workers because of the social stigma attached to IDU. The true distribution of infected individuals cannot be inferred from these data. The data do, however, provide useful information in helping to identify areas of the state that are most affected by these diseases.

## Disease Report Data–Hepatitis C (HCV)

**Table 1**

**Cumulative IDU-Related HCV Cases, 1997–1999**

| **County** (ranked in order of 3-year cum. case rate) | **Population** (Census 2000) | **Cumulative IDU-Related HCV Cases, 1997–1999** | **3-Year Cumulative Case Rate per 100,000 Population** |
|---|---|---|---|
| Washington | 33,941 | 22 | 65 |
| Knox | 39,618 | 23 | 58 |
| Cumberland | 265,612 | 133 | 50 |
| Androscoggin | 103,793 | 46 | 44 |
| Penobscot | 144,919 | 46 | 32 |
| Statewide Total* | 1,274,923 | 391 | 31 |
| Sagadahoc | 35,214 | 9 | 26 |
| York | 186,742 | 47 | 25 |
| Kennebec | 117,114 | 25 | 21 |
| Hancock | 51,791 | 7 | 14 |
| Somerset | 50,888 | 7 | 14 |
| Franklin | 29,467 | 4 | 14 |
| Oxford | 54,755 | 7 | 13 |
| Lincoln | 33,616 | 4 | 12 |
| Piscataquis | 17,235 | 2 | 12 |
| Aroostook | 73,938 | 6 | 8 |
| Waldo | 36,280 | 3 | 8 |

*Source: Disease Report Data, Maine Bureau of Health, 1997–1999*
**Statewide Total does not include one "unknown."*

Hepatitis C diagnoses with IDU as a risk factor have occurred in all Maine counties. The great majority of these diagnosed cases are likely to represent chronic infections resulting from exposures at some time in the past (rather than newly acquired hepatitis C infections). IDU-related HCV cases may represent persons who had one isolated injection episode or represent active users who have been injecting for many years. Table 1 illustrates the geographic distribution of IDU-related HCV cases in Maine from 1997–1999. Population estimates are listed along with cumulative diagnoses by county. A three-year case rate has been calculated per 100,000 population to illustrate the number of cases proportional to a county's population size and to make comparisons between counties and with the state as a whole.

Washington County has a case rate of 65, which is more than double the statewide case rate of 31 IDU-related HCV diagnoses per 100,0000 population. Notably, the numbers increased in Washington County during this three-year period from 1 case in 1997 to 17 cases in 1999. This may be due in part to the initiation of the disease reporting rules and an increased awareness of screening criteria.

Knox County has the second highest rate at 58 per 100,000 population. The high prevalence rate in Knox County is very likely related to the presence of the State Prison at Thomaston.

Cumberland, Androscoggin, and Penobscot counties all have rates that exceed the statewide case rate. These counties include three of Maine's largest cities: Portland, Lewiston/Auburn, and Bangor.

**Table 2**

**HCV Transmission Risk Factors, 1997–1999**

| HCV Transmission Risk Factors | Percentage |
|---|---|
| IDU Risk | 54% |
| Unidentified Risk | 20% |
| Transfusion/Hemophilia Risk | 16% |
| Heterosexual Risk | 6% |
| Occupational Risk | 3% |
| Male-to-Male Sexual Risk | 1% |
| **TOTAL** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1997–1999*

As illustrated in Table 2, the majority of HCV cases (54 percent) are associated with a history of IDU. This number may be even higher, as there are social stigmas associated with IDU that may inhibit a patient from revealing past or present risk factors, perhaps reflected in the unidentified risk factor category. Blood transfusion and hemophilia are the next highest risk factor for HCV.

**Table 3**

**IDU-Related HCV Cases by Age, 1997-1999**

| Age Range | Frequency | Percentage |
|---|---|---|
| 19 yrs. & under | 6 | 2% |
| 20–29 years old | 30 | 7% |
| 30–39 years old | 141 | 35% |
| 40–49 years old | 190 | 47% |
| 50 yrs. & older | 37 | 9% |
| **TOTAL** | **404** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1997–1999*

Table 3 shows that 82 percent of the cases of HCV related to IDU occur in the 30- to 49-year-old age group. Nine percent of cases occur in individuals 29 and under and another 9 percent in those who are 50 years old or older. These age categories refer to the age of the person at the time of their HCV diagnosis.

**Table 4**

**IDU-Related HCV Cases by Gender, 1997–1999**

| Gender | Frequency | Percentage |
|---|---|---|
| Male | 290 | 71% |
| Female | 117 | 29% |
| **TOTAL** | **407** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1997–1999*

As shown in Table 4, males account for the majority of IDU-related HCV diagnoses for the three-year time period at 71 percent of the total reported cases.

**Table 5**

**IDU-Related HCV Cases by Race, 1997–1999**

| Race | Frequency | Percentage |
|---|---|---|
| White/Non-Hispanic | 375 | 94% |
| Hispanic | 8 | 2% |
| Black | 5 | 1% |
| Native American | 1 | <1% |
| Other/Unknown | 12 | 3% |
| **TOTAL** | **401** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1997–1999*

Non-Hispanic whites account for the majority of HCV cases in which IDU is identified as a risk factor. As Table 5 shows, the racial distribution of cases generally appears to reflect the overall racial breakdown of the state. The case numbers are small and it is not possible to make significant conclusions regarding race and ethnicity statistics for these data.

## Disease Report Data–HIV

**Table 6**

**Cumulative IDU and MSM/IDU-Related HIV Cases, 1996–2000**

| **County** (ranked in order of 5-year cum. case rate) | **Population** (Census 2000) | **Cumulative IDU- & MSM/IDU-Related HIV Cases 1996–2000** | **5-Year Cumulative Case Rate per 100,000 Population** |
|---|---|---|---|
| Cumberland | 265,612 | 37 | 14 |
| Androscoggin | 103,793 | 10 | 10 |
| Penobscot | 144,919 | 12 | 8 |
| Statewide Total* | 1,274,923 | 87 | 7 |
| Somerset | 50,888 | 3 | 6 |
| Sagadahoc | 35,214 | 2 | 6 |
| Waldo | 36,280 | 2 | 6 |
| Lincoln | 33,616 | 2 | 6 |
| York | 186,742 | 8 | 4 |
| Aroostook | 73,938 | 3 | 4 |
| Oxford | 54,755 | 2 | 4 |
| Kennebec | 117,114 | 4 | 3 |
| Knox | 39,618 | 1 | 3 |
| Hancock | 51,791 | 1 | 2 |
| Washington | 33,941 | 0 | 0 |
| Franklin | 29,467 | 0 | 0 |
| Piscataquis | 17,235 | 0 | 0 |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*
**Statewide Total does not include two "undisclosed."*

As Table 6 illustrates, not all counties in Maine have reported IDU- and MSM/IDU-related HIV cases for this time period. The table lists counties with their 2000 population estimates, along with the cumulative number of positive HIV tests from 1996 through 2000. Three counties – Washington, Franklin, and Piscataquis –have no reported cases for the time period analyzed. Cumberland, Androscoggin, and Penobscot counties all report rates that exceed the statewide rate for the five-year time period. These counties include three of Maine's largest cities: Portland, Lewiston/Auburn, and Bangor. Cumberland County has the highest rate of any Maine county, with 14 cases per 100,000 population. This rate is twice as high as the statewide rate of 7 cases per 100,000 population.

**Table 7**

**HIV Transmission Risk Factors, 1996-2000**

| HIV Transmission Risk Factors | Percentage |
|---|---|
| Male-to-Male Sexual Risk | 45% |
| IDU Risk | 16% |
| Male-to-Female Sexual Risk | 16% |
| Female-to-Male Sexual Risk | 15% |
| Male-to-Male Sexual Risk (MSM)/IDU | 3% |
| Other | 5% |
| **TOTAL** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

As Table 7 shows, sexual contact between males is the most common mode of HIV transmission at 45 percent of all HIV positive cases from 1996 to 2000. IDU and heterosexual contact are the next most often reported modes of transmission, each at 16 percent of total cases. Female-to-male transmission was next at 15 percent, followed by male-to-male sexual risk (MSM) and IDU at 3 percent. Other types of risk accounted for 5 percent. When all IDU-related cases (including IDU and MSM/IDU) are combined, IDU-related HIV transmission becomes the second most common mode of HIV transmission at 19 percent of cases. However, transmission through IDU may be underreported because of the social stigma associated with IDU.

**Table 8**

**IDU and MSM/IDU-Related HIV Cases by Age, 1996–2000**

| Age Range | Frequency | Percentage |
|---|---|---|
| 19 yrs. & under | 2 | 2% |
| 20–29 years old | 16 | 18% |
| 30–39 years old | 47 | 53% |
| 40–49 years old | 17 | 19% |
| 50 yrs. & older | 7 | 8% |
| **TOTAL** | **89** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

Table 8 shows that the majority of IDU- and MSM/IDU-related HIV diagnoses occurred in the 30- to 39-year-old age group at 53 percent. The next highest percentage (19 percent) of cases occurs in the 40- to 49-year-old category, followed by the 20- to 29-year-olds with 18

percent of the total cases. Two percent of IDUs living with HIV received their diagnosis at 19 years of age or younger and 8 percent were aged 50 or over.

**Table 9**

**IDU and MSM/IDU-Related HIV Cases by Gender, 1996–2000**

| Gender | Frequency | Percentage |
|---|---|---|
| Male | 80 | 90% |
| Female | 9 | 10% |
| **TOTAL** | **89** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

Table 9 shows that males account for 90 percent of all HIV-positive diagnoses with IDU or MSM/IDU as a risk factor. Women make up only 10 percent of this category of individuals with HIV.

**Table 10**

**IDU and MSM/IDU-Related HIV Cases by Race, 1996–2000**

| Race | Frequency | Percentage |
|---|---|---|
| White | 66 | 74% |
| Hispanic | 6 | 7% |
| Black | 4 | 5% |
| American Indian/ Alaska Native | 2 | 2% |
| Undisclosed | 11 | 12% |
| **TOTAL** | **89** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

As seen in Table 10, whites account for the majority of HIV-positive diagnoses in which IDU and MSM/IDU is noted as a risk factor. Because the numbers are small and 12 percent of the cases are of undisclosed race, it is difficult to make more significant conclusions regarding race data.

## Disease Report Data–AIDS

**Table 11**

**IDU- and MSM/IDU-Related Cumulative AIDS Cases, 1996–2000**

| **County** (ranked in order of 5-year cum. case rate) | **Population** (Census 2000) | **Cumulative IDU- & MSM/IDU-Related AIDS Cases 1996–2000** | **5-Year Cumulative Case Rate per 100,000 Population** |
|---|---|---|---|
| Cumberland | 265,612 | 21 | 8 |
| Androscoggin | 103,793 | 8 | 8 |
| Penobscot | 144,919 | 6 | 4 |
| Aroostook | 73,938 | 3 | 4 |
| Somerset | 50,888 | 2 | 4 |
| Statewide Total | 1,274,923 | 50 | 4 |
| Kennebec | 117,114 | 4 | 3 |
| Knox | 39,618 | 1 | 3 |
| Washington | 33,941 | 1 | 3 |
| Hancock | 51,791 | 1 | 2 |
| Waldo | 36,280 | 1 | 2 |
| York | 186,742 | 2 | 1 |
| Oxford | 54,755 | 0 | 0 |
| Sagadahoc | 35,214 | 0 | 0 |
| Lincoln | 33,616 | 0 | 0 |
| Franklin | 29,467 | 0 | 0 |
| Piscataquis | 17,235 | 0 | 0 |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

Table 11 lists all Maine counties with their 2000 population estimates, along with the cumulative number of AIDS diagnoses from 1996 through 2000 and a corresponding five-year rate per 100,000 population. Not all counties in Maine have reported IDU- and MSM/IDU-related AIDS cases. The table shows that five counties have case rates that meet or exceed the statewide case rate of 4 per 100,000 population. Cumberland and Androscoggin counties have the highest rate at 8 IDU- and MSM/IDU-related cases per 100,000 population. This is twice the statewide case rate for the 5-year time period. Penobscot, Aroostook, and Somerset counties have rates equal to the statewide rate.

**Table 12**

**AIDS Transmission Risk Factors, 1996-2000**

| AIDS Transmission Risk Factors | Percentage |
|---|---|
| Male-to-Male Sexual Risk | 49% |
| IDU Risk | 19% |
| Heterosexual Risk | 17% |
| Other/Not Specified | 13% |
| Male-to-Male Sexual Risk (MSM)/IDU | 2% |
| **TOTAL** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

Table 12 shows that sexual contact between males is the most common mode of AIDS transmission at 49 percent, followed by IDU at 19 percent. Heterosexual risk is the third highest risk factor for AIDS during the five-year time period. Thirteen percent of diagnosed AIDS cases from 1996 to 2000 did not have an identified risk factor or the risk factor was related to blood transfusion or hemophilia. Combined male-to-male sexual risk and IDU accounted for 2 percent of total cases. However, transmission through IDU may be underreported because of the social stigma associated with IDU.

**Table 13**

**IDU- and MSM/IDU-Related AIDS Cases by Age, 1996–2000**

| Age Range | Frequency | Percentage |
|---|---|---|
| 19 yrs. & under | 0 | 0% |
| 20–29 years old | 2 | 4% |
| 30–39 years old | 27 | 54% |
| 40–49 years old | 16 | 32% |
| 50 yrs. & older | 5 | 10% |
| **TOTAL** | **50** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

Table 13 shows that the highest number (54 percent) of AIDS cases among IDU and MSM/IDU occurs in the 30- to 39-year-old age category. The next highest percentage of cases occurs in the 40- to 49-year-old age category at 32 percent of total cases. Four percent of cases during the five-year time period were diagnosed in individuals that were 29 years old or younger, and 10 percent were 50 or older.

**Table 14**

**IDU- and MSM/IDU-Related AIDS Cases by Gender, 1996–2000**

| Gender | Frequency | Percentage |
|---|---|---|
| Male | 39 | 78% |
| Female | 11 | 22% |
| **TOTAL** | **50** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

Table 14 shows that males account for 78 percent of all IDU- and MSM/IDU-related AIDS cases.

**Table 15**

**IDU- and MSM/IDU-Related AIDS Cases by Gender, 1996–2000**

| Race | Frequency | Percentage |
|---|---|---|
| White | 43 | 86% |
| Black | 3 | 6% |
| Hispanic | 3 | 6% |
| American Indian | 1 | 2% |
| **TOTAL** | **50** | **100%** |

*Source: Disease Report Data, Maine Bureau of Health, 1996–2000*

Table 15 shows that whites account for the majority of all IDU- and MSM/IDU-related AIDS cases. The racial distribution of cases generally appears to reflect the overall racial breakdown of the state. The case numbers are small, and it is not possible to make significant conclusions regarding race and ethnicity statistics for these data.

## Maine Office of Substance Abuse Data

The Maine Office of Substance Abuse collects data on IDUs who are admitted to and discharged from specific service providers. The data describe clients who received services at agencies funded by the Maine Office of Substance Abuse; clients who enter treatment as a result of an operating under the influence (OUI) conviction; Medicaid reimbursable clients; and clients in methadone programs. Data utilized for this report describe individuals between 1996 and 2000 who received services and had injected drugs within the previous six months of the admission. A limitation of the data is that although a client is counted only one time per year, duplication occurs if the client is admitted in multiple years. Gender information regarding IDU clients was not analyzed for this study.

The differences in rates of IDU clients are very likely influenced by differences in the availability of services from one county to another. The true distribution of IDUs in the state of Maine cannot be inferred from these data. However, the data are useful for estimating areas that may be disproportionately affected by IDU.

**Table 16**

**Cumulative IDU Client Admission Rates, 1996-2000**

| **County** (ranked in order of 5-year cum. client rate) | **Population** (Census 2000) | **Cumulative IDU Clients 1996–2000** | **5-Year Cumulative Client Rate per 100,000 Population** |
|---|---|---|---|
| Washington | 33,941 | 228 | 672 |
| Cumberland | 265,612 | 1,038 | 391 |
| Penobscot | 144,919 | 420 | 290 |
| Statewide Total | 1,274,923 | 2,542 | 200 |
| Knox | 39,618 | 75 | 189 |
| Lincoln | 33,616 | 46 | 137 |
| Hancock | 51,791 | 65 | 126 |
| Kennebec | 117,114 | 143 | 122 |
| York | 186,742 | 226 | 121 |
| Sagadahoc | 35,214 | 40 | 114 |
| Waldo | 36,280 | 39 | 107 |
| Androscoggin | 103,793 | 97 | 93 |
| Aroostook | 73,938 | 62 | 84 |
| Piscataquis | 17,235 | 10 | 58 |
| Franklin | 29,467 | 14 | 48 |
| Somerset | 50,888 | 23 | 45 |
| Oxford | 54,755 | 16 | 29 |

*Source: Treatment Data System, 1996–2000*
*Maine Department of Behavioral and Developmental Services, Office of Substance Abuse*

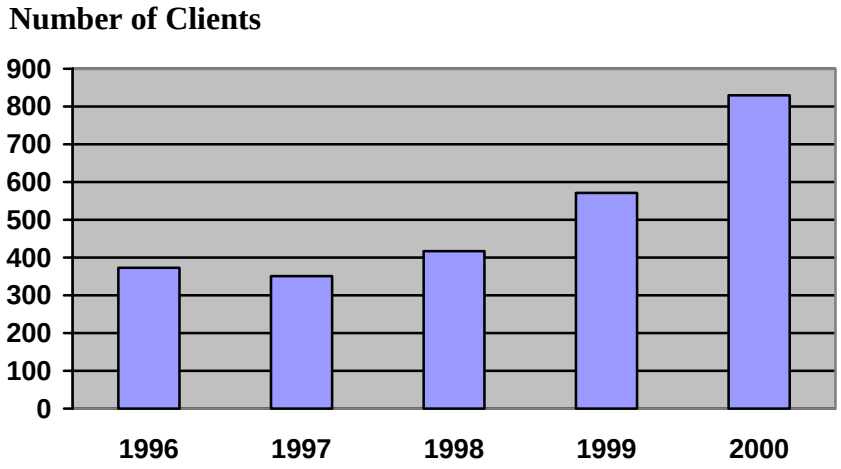
Table 16 illustrates the geographic distribution of IDU clients from 1996 to 2000. Population estimates are listed along with cumulative client admissions by county. A five-year admission rate has been calculated per 100,000 population to illustrate the number of clients proportional to a county's population size, and also to make comparisons between counties and with the state as a whole.

The ranking in Table 16 shows that Washington, Cumberland, and Penobscot counties have the highest five-year cumulative IDU client admission rates. Washington County's admission rate of 672 is more than three times the statewide admission rate of 200 per 100,000 population and almost twice the rate of Cumberland County, the second highest-ranking county.

It is important to note that the raw data show that seven counties – Aroostook, Hancock, Kennebec, Knox, Penobscot, Sagadahoc, and Waldo – experienced increases in client admissions in 2000 that were close to two times or more the admissions of previous years.

**Figure 1**

**IDU Client Admissions 1996–2000**




*Source: Treatment Data System, 1996–2000*
*Maine Department of Behavioral and Developmental Services, Office of Substance Abuse*

Figure 1 shows the annual number of IDU client admissions reported to the Office of Substance Abuse from 1996 to 2000. Admissions include any clients who reported IDU within the previous six months. After a slight (6 percent) decrease in clients from 373 in 1996 to 351 in 1997, there was a steady increase in admissions from 1997 through 2000. During this time period, admissions more than doubled (increased by 136 percent) from 351 in 1997 to 830 in 2000. It is not clear if new screening or intervention programs were introduced during this time period, possibly affecting the admission figures.

**Table 17**

**IDU Client Admissions by Age, 1996–2000**

| Year | Age 15-24 | Age 25-34 | Age 35-44 | Age 45 & older |
|---|---|---|---|---|
| 1996 | 59 | 152 | 137 | 25 |
| 1997 | 66 | 111 | 132 | 42 |
| 1998 | 87 | 149 | 138 | 43 |
| 1999 | 128 | 202 | 180 | 61 |
| 2000 | 290 | 258 | 210 | 72 |
| **5-year Total** | **630 (25%)** | **872 (34%)** | **797 (31%)** | **243 (10%)** |

*Source: Treatment Data System, 1996–2000*
*Maine Department of Behavioral and Developmental Services, Office of Substance Abuse*

Table 17 shows the number of IDU client admissions from 1996 through 2000 by age category. The majority of IDU clients are between the ages of 25 and 44. There were increases in all age categories during the five-year period. The 15- to 24-year-old category saw an increase of 391 percent from 1996 to 2000.

**Table 18**

**IDU Clients by Race, 1996–2000**

| Race | Frequency | Percentage |
|---|---|---|
| White | 2,405 | 95% |
| Black | 45 | 2% |
| Native American | 57 | 2% |
| Asian | 7 | <1% |
| Other | 28 | 1% |
| **TOTAL** | **2,542** | **100%** |

*Source: Treatment Data System, 1996–2000*
*Maine Department of Behavioral and Developmental Services, Office of Substance Abuse*

Table 18 provides information by race for total client admissions from 1996 to 2000. The majority of IDU-related admissions are among whites. This reflects Maine's racial demographic. According to the 2000 Census, Native Americans make up .6 percent of Maine's population. They account for 2 percent of the IDU client admissions from 1996 to 2000. However, because the numbers are relatively small, it is difficult to make significant statements about the data in regard to race.

## Maine Hospital Discharge Data

Hospital discharge data are collected by the Maine Health Data Organization through the Office of Data, Research and Vital Statistics. Data used for this report were taken from hospital discharge records with any mention of drug dependence involving continuous or episodic use of opium and its derivatives from 1996 to 2000. Limitations of the data include potential inaccuracy on discharge records, patients' unwillingness to disclose IDU behavior, and duplication of patients discharged from a hospital more than once during the reporting period. In addition, it is not known how many IDUs avoid going to the hospital when necessary.

**Table 19**

**Cumulative Opioid-Related Hospital Discharges, 1996–2000**

| **County** (ranked in order of 5-year cum. case rate) | **Population** (Census 2000) | **Cumulative Opioid-Related Discharges 1996–2000** | **5-Year Cumulative Discharge Rate per 100,000 Population** |
|---|---|---|---|
| Washington | 33,941 | 174 | 510 |
| Cumberland | 265,612 | 754 | 284 |
| Statewide Total | 1,274,923 | 1,917 | 151 |
| Somerset | 50,888 | 74 | 145 |
| Penobscot | 144,919 | 206 | 142 |
| Hancock | 51,791 | 71 | 137 |
| York | 186,742 | 234 | 125 |
| Lincoln | 33,616 | 42 | 125 |
| Knox | 39,618 | 43 | 109 |
| Sagadahoc | 35,214 | 34 | 97 |
| Kennebec | 117,114 | 104 | 89 |
| Waldo | 36,280 | 31 | 85 |
| Oxford | 54,755 | 41 | 75 |
| Piscataquis | 17,235 | 12 | 70 |
| Androscoggin | 103,793 | 63 | 61 |
| Franklin | 29,467 | 13 | 44 |
| Aroostook | 73,938 | 21 | 28 |

*Source: Maine Hospital Discharge Files, Maine Health Data Organization, 1996–2000*
*Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics*

Table 19 illustrates the geographic distribution of hospital discharges with mention of opioid use from 1996 to 2000. Population estimates are listed along with cumulative patient discharges by county. A five-year discharge rate has been calculated per 100,000 population to illustrate the number of patient discharges proportional to a county's population size, and to make comparisons between counties and with the state as a whole.

Washington and Cumberland counties have five-year cumulative rates that are higher than the overall statewide rate. Washington County has the highest rate of any Maine county,

with 510 cases per 100,000 population during the five-year period. This rate is more than three times the statewide rate of 151 cases per 100,000 population.

**Table 20**

**Opioid-Related Hospital Discharges by Age, 1996–2000**

| Age Range | Frequency | Percentage |
|---|---|---|
| 18 yrs. & under | 37 | 2% |
| 19-24 years old | 313 | 16% |
| 25-49 years old | 1,402 | 73% |
| 50 yrs. & older | 165 | 9% |
| **TOTAL** | **1,917** | **100%** |

*Source: Maine Hospital Discharge Files, Maine Health Data Organization, 1996–2000*
*Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics*

Table 20 shows patient discharge numbers by age category for the five-year period. The majority of patients discharged (73 percent) with mention of opioid use were 25 to 49 years old. The second highest age group with mention of opioid use was the 19- to 24-year-olds at 16 percent of the total discharges from 1996 to 2000.

**Table 21**

**Opioid-Related Hospital Discharges by Gender, 1996-2000**

| Gender | Frequency | Percentage |
|---|---|---|
| Male | 976 | 51% |
| Female | 941 | 49% |
| **TOTAL** | **1,917** | **100%** |

*Source: Maine Hospital Discharge Files, Maine Health Data Organization, 1996–2000*
*Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics*

Table 21 shows that there was almost no difference between the number of males and females reporting continuous or episodic use of opioids at time of discharge for the years reviewed in this assessment.

**Table 22**

**Opioid-Related Hospital Discharges by Race, 1996-2000**

| Race | Frequency | Percentage |
|---|---|---|
| White | 1,204 | 63% |
| American Indian | 10 | 1% |
| Black | 9 | <1% |
| Asian | 1 | <1% |
| Hispanic | 2 | <1% |
| Unknown & Other | 691 | 36% |
| **TOTAL** | **1,917** | **100%** |

*Source: Maine Hospital Discharge Files, Maine Health Data Organization, 1996-2000*
*Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics*

Table 22 shows opioid-related hospital discharges from 1996 to 2000 by race. Due to the high number of patients in the "unknown" and "other" categories, it is not possible to make any conclusions regarding race for these data.

## Maine Death Certificate Data

Maine death certificate data were collected from the Office of Data, Research and Vital Statistics in the Maine Bureau of Health. Death certificates from 1996-2000 were analyzed. Any drug poisoning death that mentioned heroin, methadone, and other related opioids where the drug was noted as a cause or contributor to the death was included in this study. Due to the often limited information available at the time of an individual's death, it is difficult to know the true impact of drug poisoning deaths in the state. Trend and race data are too small to consider in this study. Gender data are not included.

**Table 23**

**Cumulative Deaths Involving Opioid Use, 1996–2000**

| **County** (ranked in order of 5-year cum. death rate) | **Population** (Census 2000) | **Cumulative Opioid-Related Deaths 1996–2000** | **5-Year Cumulative Death Rate per 100,000 Population** |
|---|---|---|---|
| Washington | 33,941 | 5 | 15 |
| Cumberland | 265,612 | 35 | 13 |
| Oxford | 54,755 | 7 | 13 |
| Piscataquis | 17,235 | 2 | 12 |
| Penobscot | 144,919 | 15 | 11 |
| Knox | 39,618 | 4 | 10 |
| York | 186,742 | 15 | 8 |
| Statewide Total | 1,274,923 | 103 | 8 |
| Franklin | 29,467 | 2 | 7 |
| Kennebec | 117,114 | 7 | 6 |
| Hancock | 51,791 | 3 | 6 |
| Lincoln | 33,616 | 2 | 6 |
| Androscoggin | 103,793 | 3 | 3 |
| Waldo | 36,280 | 1 | 3 |
| Somerset | 50,888 | 1 | 2 |
| Aroostook | 73,938 | 1 | 1 |
| Sagadahoc | 35,214 | 0 | 0 |

*Source: Maine Vital Records – Mortality File, 1996–2000*
*Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics*

Table 23 illustrates the geographic distribution of deaths involving opioid use from 1996 to 2000. Population estimates are listed along with cumulative deaths by county. A five-year death rate has been calculated per 100,000 population to illustrate the number of deaths proportional to a county's population size, and to make comparisons between counties and with the state as a whole.

There are seven counties that have five-year death rates that meet or exceed the statewide average of 8 deaths per 100,000 population. Washington County's five-year cumulative death rate of 15 deaths per 100,000 population is nearly twice that of the statewide rate. The rates for Cumberland and Oxford counties are 63 percent higher than the statewide rate.

Piscataquis County, at 12 deaths per 100,000 population, has the fourth highest death rate followed by Penobscot and Knox counties. York County's five-year rate is the same as the statewide rate.

**Table 24**

**Deaths Involving Opioid Use by Age, 1996–2000**

| Year | Age 18 & under | Age 19–24 | Age 25–49 | Age 50 & older |
|---|---|---|---|---|
| 1996 | 0 | 2 | 9 | 2 |
| 1997 | 2 | 4 | 14 | 1 |
| 1998 | 0 | 3 | 21 | 4 |
| 1999 | 0 | 1 | 13 | 1 |
| 2000 | 0 | 1 | 23 | 2 |
| **5-year Total** | **2 (2%)** | **11 (11%)** | **80 (77%)** | **10 (10%)** |

*Source: Maine Vital Records – Mortality File, 1996–2000*
*Maine Department of Human Services, Bureau of Health, Office of Data, Research and Vital Statistics*

Table 24 presents the death certificate data by age category for the 1996–2000 time period. The majority of deaths (77 percent) occurred among individuals ranging in age from 25 to 49 years old. There was a 155 percent increase in deaths from 1996 to 2000 in this age category.

## Northern New England Poison Center Data

The Northern New England Poison Center receives approximately 10,000 calls per year to their statewide toll-free phone number. Data utilized in this report include any calls received by the center from Maine counties that involved the following injected drugs: APAP (acetaminophen) plus other meds, synthetic narcotics, analgesics, barbiturates, tranquilizers, amphetamines and other stimulants, PCP, opiates, cocaine, and street drugs. Data from 1996 through 2000 were analyzed. Since the data rely on the comprehension and collection of information by the center's volunteer staff, there may be reporting biases.

**Table 25**

**Cumulative Calls Involving Injected Drugs, 1996–2000**

| **County** (ranked in order of 5-year cum. call rate) | **Population** (Census 2000) | **Cumulative Calls Involving Injected Drugs, 1996–2000** | **5-Year Cumulative Call Rate per 100,000 Population** |
|---|---|---|---|
| Cumberland | 265,612 | 657 | 247 |
| Kennebec | 117,114 | 190 | 162 |
| Androscoggin | 103,793 | 166 | 160 |
| Penobscot | 144,919 | 224 | 154 |
| Statewide Total* | 1,274,923 | 1,960 | 154 |
| Somerset | 50,888 | 73 | 143 |
| York | 186,742 | 236 | 126 |
| Lincoln | 33,616 | 39 | 116 |
| Washington | 33,941 | 38 | 112 |
| Franklin | 29,467 | 33 | 112 |
| Knox | 39,618 | 42 | 106 |
| Aroostook | 73,938 | 78 | 105 |
| Sagadahoc | 35,214 | 36 | 102 |
| Waldo | 36,280 | 36 | 99 |
| Hancock | 51,791 | 48 | 93 |
| Oxford | 54,755 | 49 | 89 |
| Piscataquis | 17,235 | 15 | 87 |

*Source: Northern New England Poison Center, 1996–2000*
**Statewide Total does not include 217 calls of unknown county origin.*

Table 25 illustrates the geographic distribution of calls to the Northern New England Poison Center from 1996 to 2000. Population estimates are listed along with cumulative calls by county. A five-year call rate has been calculated per 100,000 population to illustrate the number of calls proportional to a county's population size, and to make comparisons between counties and with the state as a whole.

As Table 25 illustrates, Cumberland, Kennebec, Androscoggin, and Penobscot counties have the highest five-year call rates, meaning that proportional to their populations they had the greatest total number of calls during the time period studied. These counties also contain Maine's largest cities: Portland in Cumberland County, Augusta in Kennebec County, the twin cities of Lewiston and Auburn in Androscoggin County, and Bangor in Penobscot County. All four counties were higher than or equal to the statewide rate of 154 calls per 100,000 population.

## Maine Drug Enforcement Agency Data

Due to the illegal nature of IDU, IDUs may encounter law enforcement. The Maine Drug Enforcement Agency (MDEA) provides information about arrests by county in Maine (the county is the location of the arrest, not the residence of the arrestee). Arrests related to heroin use were analyzed for this study. These data were available from 1998 through 2000. Additional data are included to illustrate trends in arrests from 1996 through 2000. The MDEA data were not readily available in a more descriptive breakdown. Therefore, there are no age, gender, or race data for this source.

**Table 26**

**Cumulative Heroin-Related Arrests, 1998–2000**

| **County** (ranked in order of 3-year cum. arrest rate) | **Population** (Census 2000) | **Cumulative Heroin-Related Arrests 1998–2000** | **3-Year Cumulative Arrest Rate per 100,000 Population** |
|---|---|---|---|
| Knox | 39,618 | 15 | 38 |
| Cumberland | 265,612 | 77 | 30 |
| Lincoln | 33,616 | 9 | 27 |
| Franklin | 29,467 | 7 | 24 |
| Penobscot | 144,919 | 26 | 18 |
| Statewide Total | 1,274,923 | 166 | 13 |
| York | 186,742 | 19 | 10 |
| Washington | 33,941 | 2 | 6 |
| Kennebec | 117,114 | 6 | 5 |
| Oxford | 54,755 | 2 | 4 |
| Aroostook | 73,938 | 2 | 3 |
| Androscoggin | 103,793 | 1 | 1 |
| Hancock | 51,791 | 0 | 0 |
| Somerset | 50,888 | 0 | 0 |
| Waldo | 36,280 | 0 | 0 |
| Sagadahoc | 35,214 | 0 | 0 |
| Piscataquis | 17,235 | 0 | 0 |

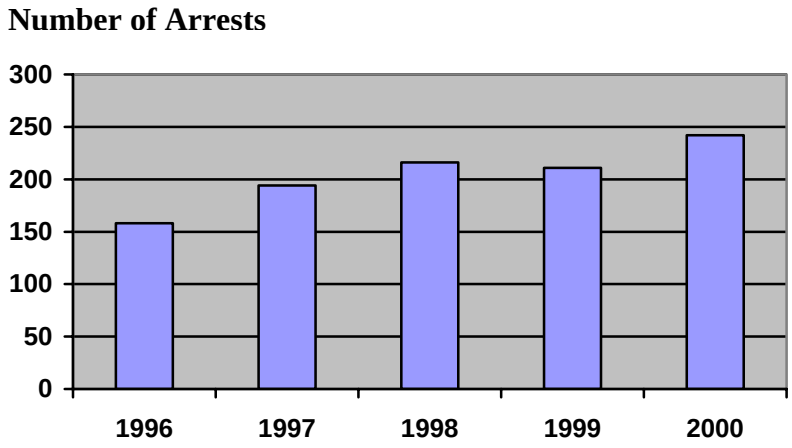
*Source: Maine Drug Enforcement Agency, Maine Department of Public Safety, 1998–2000*

Table 26 illustrates the geographic distribution of heroin-related arrests by the Maine Drug Enforcement Agency from 1998 to 2000. Population estimates are listed along with cumulative arrests by county. A three-year arrest rate has been calculated per 100,000 population to illustrate the number of arrests proportional to a county's population size, and to make comparisons between counties and with the state as a whole.

Five counties have three-year rates that exceed the statewide rate of 13 arrests per 100,000 population. As seen in Table 26, Knox County has an arrest rate that is three times that of the state rate. Cumberland County has the second highest rate at 30 arrests per 100,000 population, followed by Lincoln, Franklin, and Penobscot counties. The annual data show that arrest rates in Penobscot County rose dramatically during the three-year period, increasing from 1 arrest in 1998 to 5 arrests in 1999 and 20 arrests in 2000.

**Figure 2**

**Arrests for Possession of Opium, Cocaine, and other Derivatives, 1996–2000**




*Source: Maine Drug Enforcement Agency, Maine Department of Public Safety, 1996–2000*

Trend data regarding arrests for possession of opium, cocaine, and other derivatives were available from the Maine Drug Enforcement Agency. The user did not necessarily inject these drugs, but the data further describe the impact of potentially injectable drugs on Maine's population. Figure 2 shows the number of arrests annually from 1996 through 2000 and indicates an overall increase during the five-year period.

# PART TWO – Qualitative Data

Two primary sources were used to gather qualitative data regarding IDU in Maine. Data were collected from current or prior IDUs, as well as from service providers representing organizations that offer services to IDUs (HIV/AIDS, substance abuse, and family planning service providers). Surveys, group interviews, and individual interviews were conducted. The responses from the individual current or prior IDUs and the service providers provide empirical data to enhance the quantitative data sources.

A number of tools were utilized to collect the qualitative data. Generally, the interview and survey forms were designed to collect data regarding trends, needs, knowledge, and disease risk. Five specific questionnaire tools (see Appendix C for qualitative data interview tools and consent forms) were developed to gather this information, and the qualitative data collected from these sources are presented separately. In most cases, the questions are formatted and restated in this needs assessment exactly as they were presented to the providers and the IDUs, followed by a summary of the responses. The Key Informant Interview forms and the Penobscot County Jail group interview questions were more loosely designed. Therefore, summaries of these two tools are presented along with the corresponding data.

## General Data Limitations and Considerations

In many cases, the interview questions were open-ended and some of the questions had multiple parts, therefore the responses were often lengthy and varied. In order to compile and present the responses in summary format, a certain amount of interpretation was required. In some instances, the data have been through several iterations by more than one researcher. The responses were handwritten, adding an unknown degree of bias to their interpretation.

The open-ended nature of the survey questions frequently produced responses that were similar but unique, resulting in multiple distinct responses. When responses were deemed by the researchers to be categorical, they were grouped together and the number in parentheses following the response indicates the number of times it was mentioned. Since a respondent could have more than one (or no) answer to an open-ended question, the total number of responses per question may or may not match the number of participants.

## *Data from Injection Drug Users*

To assess the current status of knowledge, attitudes, and behaviors related to IDU and disease prevention among IDUs, current and former users were interviewed individually and in two group interviews using several different questionnaire tools. Individual interviews were coordinated and conducted by HIV prevention agencies, including Dayspring AIDS Support Services, Portland Public Health, Merrymeeting AIDS Support Services, and Down East AIDS Network. Some interviews were also conducted at Acadia Recovery Center. One of the group interviews was held at the Penobscot County

Jail in Bangor and included nine current or former IDUs. The second group interview was hosted by Portland Public Health and had six participants.

**Data Limitations**

There are some general limitations to the qualitative data collected from the IDUs interviewed for this study. The interview questions were open-ended and some of the questions had multiple parts, therefore the responses were lengthy and varied. Not all of the respondents answered all of the questions, and many did not answer all of the parts within a single question. As a result, it is not possible to track a response and make conclusions based on prior responses to a related question.

Basic demographic data (age, gender, residence, race, income, education, etc.) were collected from each group interview participant and from 35 of the 40 individual interviewees. However, the demographic data were not matched to the group interview responses or to the individual questionnaire results. Therefore, it is not possible to make statements regarding demographics and relative behavior or knowledge. A demographic description of the participants in the Portland Public Health group interview precedes the group interview summary on page 36. The demographic surveys from the 9 inmates of Penobscot County Jail and the 35 individual interviewees who completed the demographic survey were grouped together. A collective description of the demographics for these two populations follows.

**Participant Demographics**

Forty-four current or prior IDUs filled out demographic surveys. This includes 9 males from the Penobscot County Jail and 35 individuals from various HIV prevention organizations throughout the state. Participating IDUs represented the following counties: Cumberland, Hancock, Kennebec, Knox, Lincoln, Penobscot, Sagadahoc, Somerset, Washington, and York. They ranged in age from 17 to 53 years old. There were 26 male and 18 female participants. The majority of interviewees were white (40). Three individuals were of Native American descent and one identified as Hispanic.

Thirty-five of the participants had at least a high school education or more. Twenty-one of the participants reported an income for the previous year of less than $10,000. Nine interviewees reported an income in the range of $10,000 to $19,9999, 10 made between $20,000 and $29,9999, and 4 reported making $30,000 or more. Nine of the individuals were inmates at the Penobscot County Jail (see Penobscot County Jail Group Interview).

## Individual Interviews with IDUs

Forty current or former IDUs responded to a 22-question interview form designed to collect data regarding knowledge, attitudes, and behaviors relating to IDU and disease risk/prevention. The participants were interviewed at various HIV prevention agencies throughout the state. In some cases the participants were interviewed individually and others participated in small group discussions. The complete data to the 22-question interview form are available for 40 respondents (see Appendix D). A summary of the individual responses is presented below. The summary results provide information about the interviewees' disease risk and health status; an assessment of their HIV prevention and service awareness; and general information regarding IDU practices and behaviors.

## Data Limitations

As previously mentioned, the qualitative data have several limitations. Due to the open-ended nature of the interview questions, and because some of the questions had several parts, responses were lengthy and varied. In order to compile and present the responses in summary format, a certain amount of interpretation was required. In some instances, the data have been through several iterations by more than one researcher. This imparts an unknown degree of bias to the data. In addition, the demographic survey forms were not matched to the individual questionnaire responses. Therefore, it is not possible to make statements regarding gender, age, race, etc.

It is important to note that not all of the respondents answered all 22 of the interview questions. Some of the questions lent themselves to multiple responses from one or more individuals. Also, the data include responses from a group of eight individuals who were convened to answer this questionnaire. It is possible that their responses were influenced by group discussions, which may have biased some of the results.

The IDUs interviewed were convenient samples of former and current users associated with HIV prevention centers throughout the state. These are individuals who are likely to have received services or information from the agencies hosting the interviews, possibly distinguishing them from IDUs who have not accessed the health care system or received intervention services.

## Individual IDU Interview Summary

Risk Assessment and Health Status

The individual interview responses indicate that this group of current and former IDUs views using clean needles and works, and practicing safe sex (condoms), as the most likely ways to reduce their risk of contracting HIV. Although 72 percent of respondents are concerned about HIV/AIDS and hepatitis C, only 45 percent feel they are at risk for HIV. Of those that do not feel at risk (55 percent), half report they do not practice risky behaviors and half report no risk because they are in recovery or incarcerated. Most of the respondents seemed to have a general understanding of which behaviors put them at risk of contracting HIV and other blood-borne diseases, however several of the respondents noted that when they are high, safe practices are not a priority.

Ninety-four percent (32) of the respondents who answered the question regarding testing for HIV stated that they had been tested – the majority having been tested in the last three to six months. Approximately half that number (18) had been tested for hepatitis, accounting for only 53 percent of the respondents. All of the respondents recommended that other IDUs receive testing for both HIV and hepatitis, noting the prevention and treatment advantages of knowing one's status.

Several questions were designed to ascertain information regarding IDUs' access to health care services. Of the 35 individuals who answered the question about having a regular doctor, 66 percent said that they did have a regular doctor. The majority (11) of those who answered the follow-up question regarding the location of their doctor stated

that they received services in an office setting. Fourteen out of 20 respondents who answered the question about whether or not their provider knows of their IDU status said that they had shared this information with their provider. Almost half of the 25 individuals who provided information regarding payment for health care services were Medicaid recipients. Six interviewees had private health insurance, 1 had Medicare benefits and 6 were uninsured.

Prevention Information and Services

All of the respondents had received or come in contact with information and prevention services about HIV/AIDS. The media and HIV/AIDS services organizations were sited as the most common sources for prevention information, followed by schools, needle exchange programs, and methadone clinics. The participants reported receiving written information, testing services, clean needles, bleach kits, and condoms from programs and organizations with which they had come in contact. Most of the respondents made positive comments about the prevention information and services they had received.

Several respondents supported the use of peer educators and former users to reach out to IDUs. Substance abuse treatment centers, detox sites, methadone clinics, and jails were sited by respondents as the best locations to reach IDUs. Keeping law enforcement out of any intervention strategies was suggested in an effort to reduce fear and gain trust in the IDU community – two major barriers to reaching IDUs. Many of the interviewees stressed the isolation and privacy associated with IDU. To gain trust, outreach workers must have a general sensitivity to the IDU culture or personal experience with drug use in order to be most effective.

When asked specifically about needle exchange, purchasing clean needles through pharmacies, and bleach kits, the interviewees indicated support for all three services. Ninety-three percent of those who answered the question about the efficacy of needle exchange indicated support for the service. Longer hours, additional locations, and mobile services were noted as ways to increase the effectiveness of this intervention. The majority (63 percent) of respondents supported the idea of pharmacies selling needles, but 14 of the 27 individuals who answered this question mentioned discriminatory practices they or others had encountered when trying to purchase clean needles. Most who were not in favor of this service as a source for clean needles had prior negative experiences, inconsistent treatment, or were afraid of being asked for identification. Most (71 percent) of those interviewed regarded bleach kits as a good prevention strategy, but many of the respondents made cautionary statements regarding proper instruction and potential disease-prevention limitations.

Interviewees were asked to comment about their needs related to drug use cessation. A supportive environment – i.e., adequate family support, social support, and the unbiased support of the medical community – was the most frequently mentioned requirement to stop using injectable drugs. This was followed by substance abuse treatment and rehabilitation services, which were generally seen by the interviewees as good long-term recovery strategies. Methadone treatments were seen by 14 of the respondents as “just another drug” and were not considered a valid long-term recovery option.

IDU Practices and Behaviors

When asked what drugs they were currently injecting, the group of respondents mentioned a total of 17 different drugs. Heroin (17) and OxyContin (13) were the top two drug types mentioned that were specifically being injected by the respondents. Numerous other drugs and drug categories were also mentioned but not necessarily injected. The range of drugs currently being used included everything from crack/cocaine to cigarettes, alcohol, and keyboard cleaner. Marijuana and alcohol were the most mentioned drugs (15 and 14 respectively) used in the past by the interviewees.

When asked about the people with whom they inject, respondents most frequently mentioned friends and partners or spouses. Injecting alone was mentioned 10 times, but those who said that they injected alone did not do so all the time and were aware of the risk of overdosing when by themselves. Ninety-two percent of the respondents said that they inject themselves, but 16 of those who said they inject themselves reported that they were initially injected by other users until they learned how to self-inject.

Most of the interviewees said that they acquire needles primarily through pharmacies and friends, followed by the needle exchange program and diabetic family members or friends. Forty-four percent of the responses to the question regarding the difficulty or ease of getting clean needles indicated that the users participating in this assessment find it difficult to acquire clean needles. Eighty-one percent of those interviewed shared needles with other users or had shared needles at some point in the past, primarily with friends or partners. Ninety percent currently shared or had a history of sharing their works. Many of the respondents demonstrated an awareness of the risk associated with sharing used needles and works, and did not share all of the time. They were more inclined to share when injecting with individuals they felt they knew well or when they were high and safety was not a priority.

The respondents mentioned a variety of methods for disposing of their needles. The choice of disposal varied depending upon the environment in which they were using and/or their fear of being caught possessing needles. Disposing of needles in the trash with a solid container (15) or without a solid container (10) were the most frequently mentioned methods of disposal, followed by a solid container through the Portland Needle Exchange (9).

## Penobscot County Jail Group Interview

### Data Limitations

There are some unique limitations to the Penobscot County Jail group interview data. Some of the inmates that participated in the group interview had no history of IDU. The researchers conducting the group interview were able to determine that 9 of the approximately 20 participating individuals had a history of IDU, and their responses are included in this assessment. The group was presented with 18 questions relating to IDU and the associated risk of contracting HIV and/or hepatitis C. The interview was loosely structured, and the notes to describe the group responses are brief and in summary format. It is not clear how many individuals answered each question. Consequently, this

group interview offers a general impression of those interviewed but does not lend itself to conclusive summary statements for each individual question.

**Penobscot County Jail Group Interview Summary**

Some basic knowledge regarding the prevention of blood-borne diseases, such as HIV/AIDS and hepatitis C, was evident in the group. There was an awareness that safe sex, condom use, abstinence, using clean works, and not sharing needles were all "safe" behaviors that would reduce the risk of contracting HIV and/or hepatitis C. Promiscuity and sharing works were considered risky or "unsafe" behaviors. Six of the nine group members reported receiving information regarding HIV and hepatitis C from jail, school, or at home. Not all of the inmates considered the HIV/hepatitis C prevention information helpful, and at least one respondent said that the information is only helpful if the recipient is ready to listen.

In terms of services, needle exchange was cited as an effective intervention for IDUs. Nighttime accessibility to needle exchange was recommended as a way to improve upon existing services because pharmacies are generally closed at night. The respondents were also asked what they thought about the methadone clinic. One individual noted the risk of having to drive to the clinic and the additional risk of then driving on methadone following a treatment. Willingness of the user to pursue treatment was noted as a critical component of a successful outcome. When asked about pharmacy experiences, the inmates seemed to indicate that they were more likely to use a pharmacy at which they did not have to present identification.

Several of the questions related to the group's impression of current IDU trends outside of the jail setting. The group responses seem to indicate that there is a notable population of young IDUs. The inmates reported seeing 8$^{th}$, 9$^{th}$, and 10$^{th}$ graders injecting drugs such as heroin. At least two inmates describe the current problem as similar to IDU problems in large cities. When asked what IDUs are using, the inmates listed heroin, cocaine, OxyContin, Dilaudid, and morphine. It was noted that heroin was relatively inexpensive and that OxyContin was a more expensive drug. One participant stated that he was unaware of his OxyContin addiction until he was "coming off them," and another inmate said he had never considered using OxyContin until is was prescribed to him for back pain.

When asked about their current environment, the participants noted that it is difficult to attempt detox while incarcerated, as there is much ridicule and isolation during the detoxification process. In order to keep clean, the participants said that they need peer-based educational services. There are no programs in the jails now that address their needs. It was suggested that they and others could most effectively learn risk-reduction behaviors by hearing about other people's experiences with drug use and with blood-borne diseases like HIV and hepatitis C. There was a general sense that services outside of the jail community are sorely lacking, and none of the respondents felt their needs would be addressed when they were released.

## Portland Public Health Group Interview

### Data Limitations

The group facilitators presented seven questions to the participants. The questions primarily sought to ascertain the participants' knowledge regarding HIV risk factors and disease prevention. The assumption was made that there were HIV negative and positive individuals present, as well as participants who had not been tested. It is not clear from the notes taken during the group interview exactly how many individuals shared in the collective responses. Consequently, a general sense of the group's overall response is reported in the summary below. For specific questions and responses, see Appendix E.

### Participant Demographics

Three male and three female individuals participated in the Portland Public Health group interview. They ranged in age from 39 to 53 years old. Both current and former IDUs were represented. All participants were white. There was a range in educational backgrounds: two indicated 8$^{th}$ grade or below, one had some college experience, one had a two-year college degree, one had a four-year college degree, and one participant had a graduate degree. Four of the participants made less than $10,000 last year, and the other two reported making between $10,000 and $19,999. When asked about the three most important things in their lives, five of the respondents listed family members (mother, children, spouse) and pets as a top priority. The sixth respondent listed sobriety.

### Portland Public Health Group Interview Summary

The group demonstrated a general awareness of behaviors that would reduce their risk of contracting HIV. Abstinence, using clean needles and works, and not sharing works were noted to be "safe" behaviors. Sharing needles and works, unsafe sexual practices, and improper bleaching of needles were considered by the group to be "risky" behaviors. Maintaining one's overall health was seen by at least one group member to reduce the risk of contracting HIV. All of the participants considered themselves to be at risk of contracting HIV when they are not utilizing good prevention strategies.

All members of the group had received information and prevention services related to HIV. Several service organizations and a jail were noted as sources for information and services, such as safe sex messages, condoms, and clean needles. Better utilization of services and a greater knowledge of risk were sited as a result of the information/services received. According to the group, comprehensive, nonjudgmental, harm-reduction-based approaches to educational services are most effective and best received from peer educators versed in the culture of the IDUs. Access to former users was noted as a benefit of services available at Portland Public Health. When speaking of HIV (and hepatitis C) service needs, affordability – for diagnosis, treatment, and prescriptions – was a critical component of accessing care.

The group expressed some concerns regarding methadone clinic treatments. The misuse of split doses and "take-homes" may make methadone more readily available on the streets. Additionally, some participants expressed dissatisfaction with services received

at methadone treatment centers and would like to see more treatment options – like detoxification – instead of relying on methadone maintenance.

Several barriers to providing services were noted by the group. IDUs are aware of the social stigma associated with their habit, inhibiting outreach interventions. Fear of law enforcement promotes isolation, as well. IDUs are often reluctant to utilize intervention services. To overcome these barriers, the group suggested using peer educators and former users to approach IDUs in homeless shelters, at treatment facilities, and in other locations former or current users might suggest. Interventions that focus on developing trust and providing harm-reduction services will have the greatest impact on behavior.

The participants were asked about the efficacy of specific intervention services. Overall, the group felt that needle exchange is an effective way to reduce the risk of disease transmission and that more options for needle exchange should be available. The option of purchasing needles through pharmacies was generally seen as a good strategy to encourage the use of clean needles. However, the group expressed dissatisfaction with the inconsistency among pharmacies and their willingness to sell needles to users. When asked about bleach kits, there was some discussion regarding the proper procedure for utilizing bleach, and the participants were unclear about the efficacy of this method for disease prevention.

## *Data from Service Providers*

Two tools were utilized to collect data from provider organizations around the state. A Service Provider Survey was designed to collect information regarding client demographics, access to care, and provider needs from individuals who work directly with IDUs. A Key Informant Interview questionnaire was developed to obtain data and descriptive information from individuals with several unique perspectives on the issue of IDU and associated risks. (See Appendix B for survey/interview forms.)

### Service Provider Survey

#### Survey Participants

Fourteen individuals from the organizations listed below participated in the Service Provider Survey. There were three respondents from Portland Public Health, two from Coastal AIDS Network and Dayspring AIDS Support Services, and one from each of the remaining service organizations. The survey participants provide a range of services to IDUs, including outreach and support services; HIV prevention, testing, counseling, and case management; needle exchange; harm-reduction counseling; and family planning and reproductive health care. The responses to the survey provide data regarding the participants' personal experiences with IDUs.

*Participating Organizations*
*AIDS Lodging House*
*Coastal AIDS Network*
*Dayspring AIDS Support Services*
*Down East AIDS Network*
*Eastern Maine AIDS Network*
*Merrymeeting AIDS Support Services*
*Mid Coast Health and Family Planning*
*New Beginnings*
*Portland Public Health/Needle Exchange*
*PreventionWorks Harm Reduction Services*

**Data Limitations**

There were 10 open-ended questions that had multiple parts. Not all of the respondents answered all of the questions, and many did not answer all of the parts within a single question. The survey tool was self-administered. A certain amount of interpretation was required to compile and present the handwritten responses. This imparts an unknown degree of bias to the data. Appendix F includes the survey questions and a compilation of the participants' responses.

**Service Provider Survey Summary**

Nearly 20 drug types were identified as being injected by users serviced by the providers participating in the survey. Heroin was the drug most frequently named, followed by OxyContin, cocaine, and Benadryl. Three providers indicated an increased usage of OxyContin, which was also noted as a new drug of choice. Two providers sited a decrease in crack/cocaine. Age ranges varied and covered the spectrum from 15- to 50-year-olds and older. More than one provider indicated that younger individuals are using OxyContin and older clients are using heroin. There is a general sense that the age of users is increasingly younger.

Six respondents noted that they see more males injecting than females. Four indicated no difference in the gender of IDUs. The type of service provider completing the survey influenced the responses (i.e., family planning clinics see primarily female clients). One provider noted an increase in young women using injectable drugs. Half of the respondents felt that no one ethnic group is injecting more than another and that usage reflects Maine's general ethnic demographic – predominantly Caucasian. One provider indicated seeing more Native American women than women of other ethnic groups.

Five of the survey participants indicated that they are seeing more IDUs in the occupations of clam digging and fishing. Others noted no correlation between occupation and IDU. Four providers indicated that poverty/unemployment is a risk factor for their clients. An equal number of providers (4) saw no correlation between socioeconomic status and injection use.

Most of the respondents (12) felt that IDUs are most frequently shooting in private homes, but a wide range of indoor and outdoor locations were mentioned. Only one

respondent commented on what a typical shooting gallery might look like in Maine, describing it as a rotation among homes.

In addition to the demographic data regarding their clients, the providers were asked questions regarding barriers to providing services. They were also asked to describe their organizational needs. Six of the respondents noted that difficulties in establishing and maintaining trust with their clients are a large barrier to providing care. IDUs are often fearful of incarceration, and female clients have major concerns regarding custody issues for their children. There is a general distrust of programs and agencies providing services to this at-risk population, and the societal stigma associated with IDU prevents many individuals from seeking help. Most of the agencies participating in this survey indicated a need for further funding to educate staff and to establish networks of care.

## Key Informant Interviews

### Interview Participants

Key Informant Interviews were conducted with five individuals who work in varying capacities with IDUs: a substance abuse/HIV education counselor from an AIDS service organization; a counselor from a methadone clinic; an administrator from the Maine Office of Substance Abuse; a representative from the Maine Drug Enforcement Agency; and a former IDUs now active in substance abuse prevention. The interview questions were designed to collect descriptive data regarding trends that may be occurring with IDU, changes observed during the past five years, as well as user and provider needs. The informants were also asked what type of information should be collected from IDUs to enhance intervention services. The unique personal experiences summarized below provide additional qualitative data to describe IDU in Maine.

**Key Informant Number One:** *HIV Educator/Case Manager*

The interviewee has a background in substance abuse counseling, and works as an HIV educator and case manager at an AIDS intervention program in central Maine. In response to the questions regarding current IDU and possible changes over the past five years, the informant theorizes that the population is getting younger. In regard to the emotional needs of users, experience suggests that they need to feel worthy of care, and they need to be convinced they will receive intervention services without judgment and fear. Primary needs such as food, housing, and healthcare top the list of actual needs, followed by low-barrier needle exchange and methadone education/services. Providers need access to the population through food banks, soup kitchens, and the housing authority in order to treat those that are not easily identified (i.e., users receiving HIV/AIDS services.)

As a counselor, this interviewee would like to know more about IDUs' attitudes regarding hepatitis and HIV: how it affects their lives if they are infected, what they would do if they found out they are positive, their knowledge regarding prevention practices, and whether or not they care about the risk of blood-borne illnesses. In terms of long-term intervention steps, this interviewee suggests a state-mandated tracking

system that would provide statewide data to better describe the existing IDUs population, and to identify trends and populations at greatest risk.

**Key Informant Number Two:** *Program/Case Manager at a Methadone Clinic*

The interviewee provides counseling services to methadone patients in Maine on an outpatient basis. The population is described as primarily in the 18- to 30-year-old range. Fishermen and Native Americans are two specific population groups described as receiving services. The informant notes no difference in client gender. The clinic provides services to individuals from northern New Hampshire, York County, Gray, Owl's Head, New Gloucester, Bath, and Rockland. Four years ago, the clinic had 200 clients. Currently, the clinic serves 565 clients. There is a freeze on admissions and a waiting list of 15 individuals.

According to this key informant, the primary needs of IDUs are guilt-free needle exchange services, healthcare, and general education. Based on personal experience with IDUs, the informant relates primary client concerns as (1) the need for more knowledgeable providers; (2) the fear that their children will be taken away from them; (3) the need for adequate dental care; and (4) the fear of law enforcement officers who are not educated in methadone treatment services.

**Key Informant Number Three:** *Representative, Maine Office of Substance Abuse*

The third interviewee is a specialist in methadone treatment services. Although not on the front lines of IDU intervention services, the informant has a broad base of programmatic knowledge and access to the treatment data system operated by the Office of Substance Abuse. (The treatment data system collects demographic and substance data from clinics statewide – see Social Impact Indicators.)

In terms of current drug use trends, the interviewee theorizes that there is an increase in services provided to individuals in the 18- to 27-year-old range and in Native American populations. There seems to be an increase in OxyContin use and an increase in IDU overall. There are two primary needs suggested by the key informant: (1) needle exchange and (2) hepatitis B and C services (testing, treatment, and vaccination).

**Key Informant Number Four:** *Representative, Maine Drug Enforcement Agency*

The key informant from the Maine Drug Enforcement Agency (DEA) does not deal directly with IDUs, but reports on past and current experiences on behalf of the state officers. In terms of the demographics of current users, the interviewee surmises that they are young and mostly white. They are injecting heroin and OxyContin, as well as other substances. There has been a rise in heroin arrests in the Farmington area. The Lewiston/Auburn region sees more cocaine use than heroin, and the Washington County-area officers are seeing more prescription drug use. Four years ago, 10 percent of arrests were heroin related; now heroin accounts for 18 percent, and all opiates combined account for 43 percent of arrests statewide.

The interviewee describes heroin in Maine as some of the purest in the New England area. There are no labs in Maine, but there is a distribution network from northern Massachusetts that originates in New York, moves through Connecticut, and continues

north. Drugs are sold in hotels and in apartments. Users start by snorting or taking drugs in pill form and then move on to injection. In recent years, local offices are seeing more discarded syringes in communities and on the streets.

The interviewee feels that to address IDU, there needs to be an increase in prevention services; improved access to treatment services for those in Maine jails; and greater resources available overall for agencies working with IDUs. The Maine DEA itself is understaffed, having seen a decrease in agents from 70 to 26 in 1994. Therefore, arrests are opportunity-driven, with little time for intelligence gathering and investigation. The DEA provides prevention outreach in the schools, and in collaboration with other interested agencies, is developing a prevention curriculum for school-age youth.

**Key Informant Number Five:** *Former IDUs and Prevention Advocate*

A former injection drug user provides a unique perspective on the needs and experiences of the population under study. In the interviewee's current role as an advocate for the IDU population, there is a general sense that the population of clients served is increasingly younger. When asked about IDUs' most critical needs, the informant identifies four basic services: (1) methadone; (2) low-barrier needle exchange (utilizing a van for greater mobility); (3) IDU and methadone education; and (4) individuals to assist with Supplemental Security Income (SSI) and disability applications.

**Key Informant Interview Summary**

All five respondents described their clients as primarily young, with an increase in the 18- to 27-year-old population cited by one provider. An increase in heroin and OxyContin is noted by two of the providers, and the DEA representative mentions an increased presence of drugs and drug paraphernalia. Client numbers are on the rise along with their need for services. Access to knowledgeable providers, healthcare and screening services, and needle exchange are listed as top priorities. In addition, general necessities such as food, housing, clothing, and education are sorely lacking. All five interviewees noted the importance of networking and establishing comprehensive services for IDUs in order to address their immediate issues as well as their long-term needs.

# PART THREE –Key Findings and Recommendations

IDU has health and social impacts in every county in Maine. HIV and HCV cases through IDU transmission have occurred in every county in the state. The state's health, social service, and criminal justice institutions are working to intervene effectively in the problems linked to injectable drug use. For these efforts to be most effective, it is important to better understand the needs of Maine's IDUs and adapt the services to best address those needs.

Appropriate HIV prevention interventions should address the concerns and barriers that prevent IDUs from accessing services and altering their behavior to reduce the risk of contracting blood-borne diseases. This needs assessment is an effort to describe the scope of IDU in Maine and its impact on communities. Findings from this assessment can be used to focus resources and community attention where it is most needed. Additionally, this assessment identifies HIV and HCV prevention needs of IDU. Findings from this assessment can be used by organizations and individuals working with IDUs to identify the unmet prevention needs of IDUs and to develop effective HIV prevention interventions for them.

## *Key Findings*

The following concluding statements highlight significant findings from the quantitative and qualitative data sources utilized in this assessment. Key points and recurring themes are noted.

### Quantitative Data

Quantitative data for this needs assessment included a total of eight health impact and social impact indicators during the time period 1996-2000. When all eight indicators are looked at together, some regional differences emerge in the total impact of IDU. Cumberland County is experiencing an impact from IDU that exceeds the statewide average on all eight health and social indicators. Penobscot County is above the statewide average on seven out of eight indicators. Washington, Knox, and Androscoggin counties are above the statewide average on four out of eight indicators.

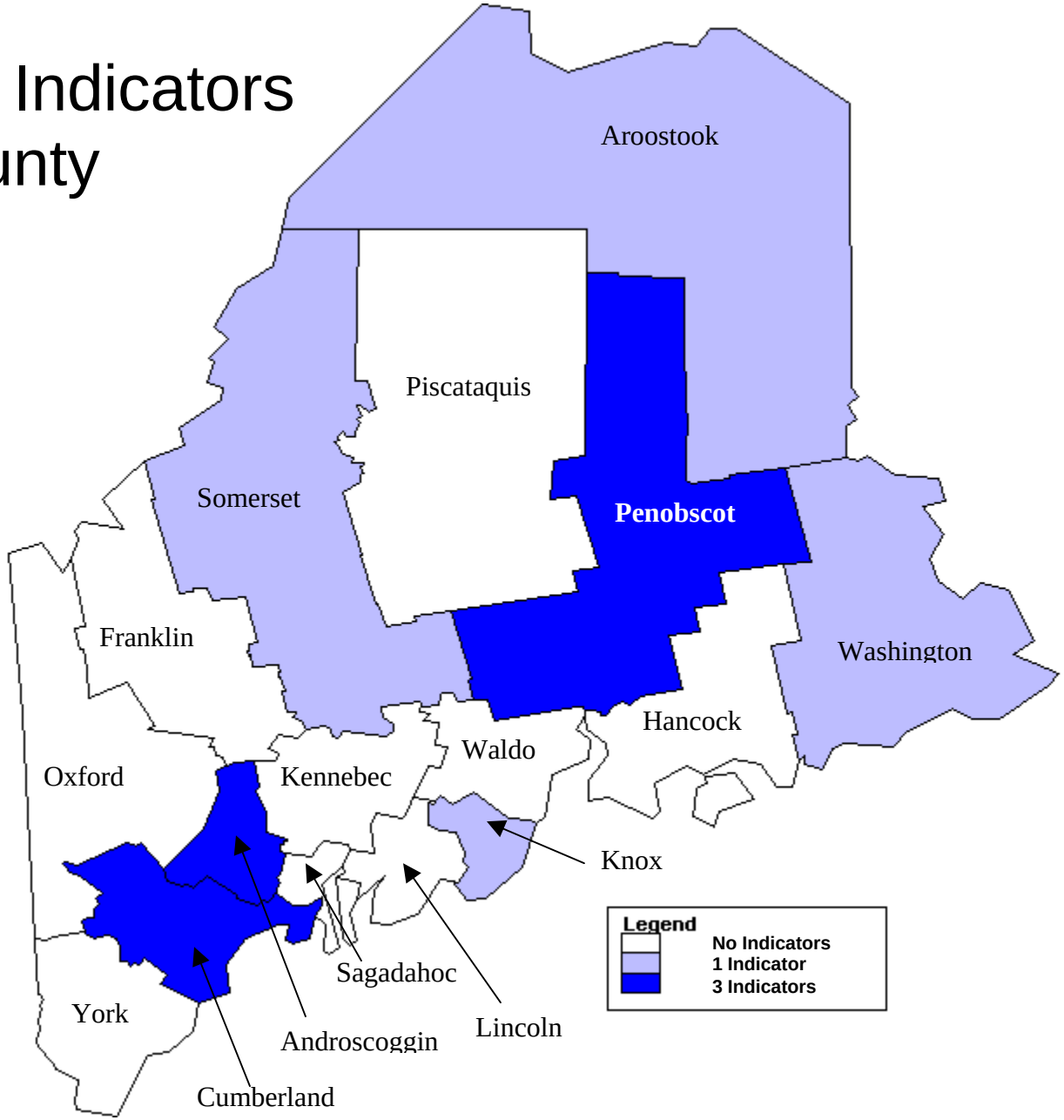
#### *Health Impact Indicators*

The three health impact indicators are cases of HIV, AIDS, and HCV caused by transmission through IDU. There are some demographic differences that emerge from the blood-borne disease information. Additionally, there are some regional differences that emerge.

- Males account for the majority of IDU-related HIV and HCV infections as well as IDU-related AIDS diagnoses.

- The majority (53 percent) of HIV cases related to IDU and MSM/IDU occur in the 30- to 39-year-old age group.

# Health Indicators by County



- Almost half (48 percent) of IDU-related AIDS cases occur in the 30-to 39-year-old age group.

- Most (82percent) of IDU-related HCV cases occur in the 30- to 49-year-old age group.

- Cumberland, Androscoggin, and Penobscot counties have disease rates for all three diseases that are higher than the statewide rates. Cumberland County has the highest HIV rate (twice the statewide rate) and AIDS rate (nearly double the statewide rate) in the state.

- Washington County has the highest rate (more than double the statewide rate) for HCV in the state.

***Social Impact Indicators***

The five social impact indicators used for this needs assessment are substance abuse treatment admissions of IDUs, poison control services for IDUs, hospital discharges of people who use opioids, deaths caused or contributed to by heroin and opioid-related drugs, and heroin related arrests. There are some demographic differences that emerge from the social impact indicators. Additionally, there are some regional differences that emerge.

- IDU-related substance abuse treatment admissions increased by 136 percent from 1997 to 2000. Admissions in the 15- to 24-year-old age category increased almost fourfold (391 percent) from 1996 to 2000.

- Most (73 percent) of opioid-related hospital discharges from 1996 to 2000 involved individuals in the 25- to 49-year-old age category.

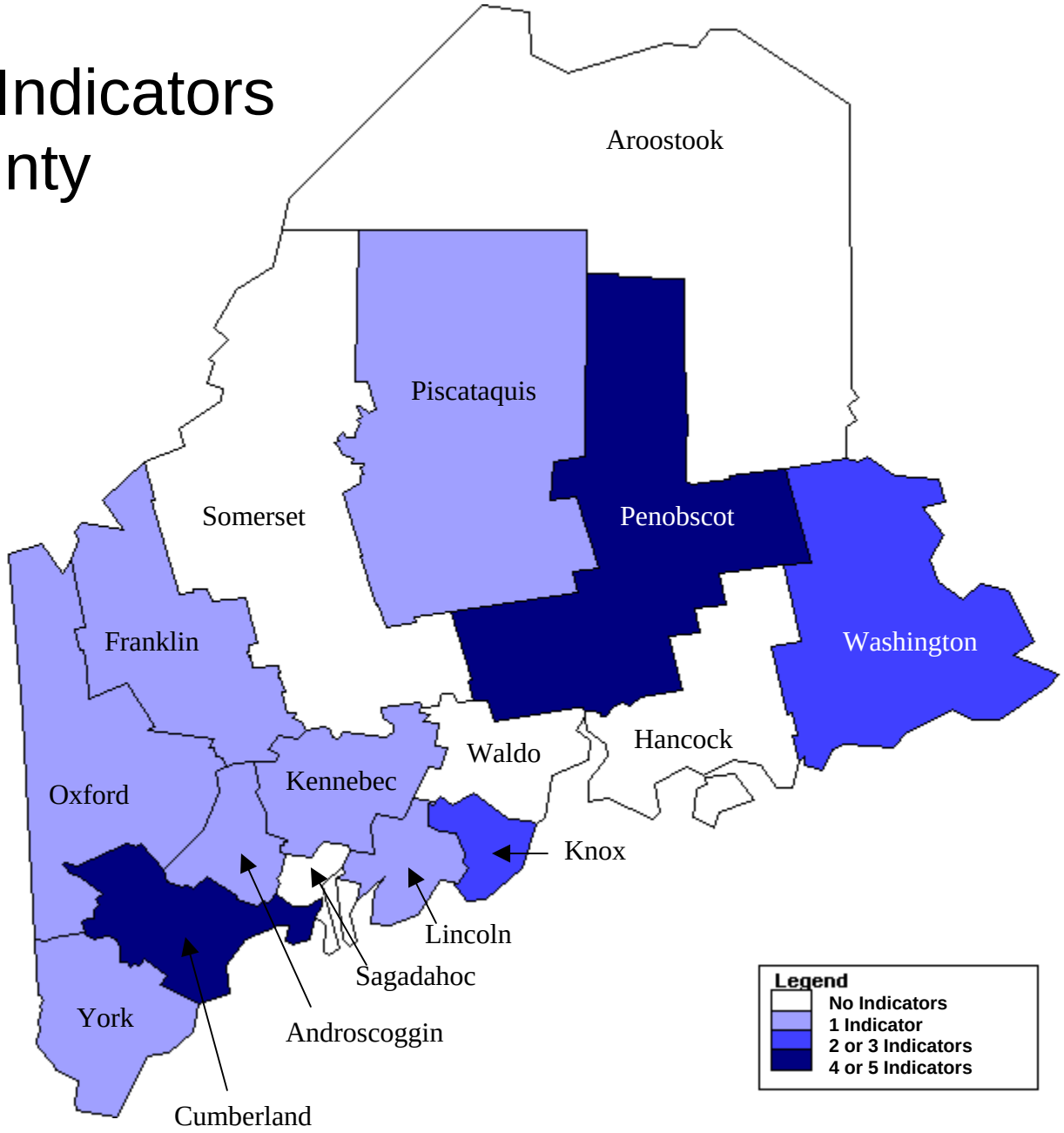
- The majority of deaths (77 percent) related to opioid use occurred in the 25- to 49-year-old age group.

- Cumberland, Penobscot, Washington, and Knox counties appear on multiple social impact indicators with rates higher than the statewide rate. Androscoggin, Franklin, Kennebec, Lincoln, Oxford, Piscataquis, and York counties appear on one social impact indicator with rates higher than the statewide rates.

- Washington County has a rate three times the statewide rate for both IDUs admitted to substance abuse treatment and for opioid-related hospital discharges.

- Washington County's five-year cumulative death rate involving opioid use is nearly twice that of the statewide rate.

# Social Indicators by County



***Qualitative Data***

Some general findings emerge from the information gathered by interviewing IDUs and service providers.

- Heroin and OxyContin were most often noted as the current drugs being injected. However, a wide spectrum of illicit, prescription, and over-the-counter drugs are being injected throughout the state.

- There is a general sense from all qualitative data sources that the age of IDUs in the state is increasingly younger.

A number of general findings emerge from the information gathered in individual and group interviews of current and former IDUs. These findings, and those summarized in the quantitative data section, can be used by service providers to develop more effective and accessible HIV prevention interventions for IDUs. The general findings are summarized below.

- Lack of trust, fear, and stigma are the most commonly reported barriers to IDUs accessing services.

- Peer education by IDUs who are known in the IDU community and versed in the language and culture of IDU, are seen by IDUs as an important way of making services more accessible.

- Almost all the IDUs in this sample demonstrated good, basic knowledge of how HIV/AIDS and HCV are transmitted both through blood and sex, but may not practice safe behaviors when high and/or using with friends or partners.

- The majority of IDUs in this sample share or did share both needles and works.

- Needle exchange programs were supported by most IDUs in this sample, along with a need for increased accessibility.

- Most IDUs in this sample got their needles from pharmacies and supported this option, although there was a general dissatisfaction with inconsistencies among pharmacies' selling practices.

- There was disagreement among IDUs in this sample regarding the efficacy of bleach kits.

- The majority of IDUs in this sample had received HIV prevention education services.

- The majority of IDUs in this sample are concerned about getting HIV and HCV.

- The majority of IDUs in this sample had been tested for HIV and about half for HCV.

- About two thirds of the IDUs in this sample had regular health care, and Medicaid insured about half of those. Most of the IDUs with primary health care providers had informed their providers of their IDU status.

## *Recommendations*

Based on the findings of this needs assessment, the following strategies for IDU-related HIV prevention interventions are recommended:

- **Use peer educators to provide interventions for IDUs.** Interviewees felt that known IDUs (former and current users), versed in the culture and language of IDU, are the best people to deliver prevention messages. The use of peer educators reduces the lack of trust, fear, and stigma-related issues that are barriers for IDUs to access services. Peer educators can deliver scientifically researched interventions that have been proven effective in other parts of the country.

- **Increase the number and accessibility of needle exchange programs.** Almost all (96 percent) of IDUs in this sample favor needle exchange programs. Nonfederal funds should be secured to provide new needle exchange services in Maine. IDUs identified important ways that access to needle exchange programs need to be improved, including expanded hours (such as at nights and weekends), and mobile exchange programs.

- **Assure easy access to new needles through pharmacy sales**. The most common way IDUs in this sample obtained clean needles was from pharmacies. It is legal to buy syringes without a prescription. The Maine Pharmacy Association fully supports the sale of syringes by pharmacies for legitimate public and individual health reasons. However, IDUs cite discriminatory sales practices among some pharmacies that create a barrier to buying syringes. Pharmacy staff should be educated about the law and the public health benefits of syringe sales to assure easy access to new syringes, free from discriminatory sale practices, pharmacy-imposed barriers to sale, and/or pharmacy staff prejudice.

- **Develop a consistent message regarding the efficacy of bleach kits.** The majority of IDUs agreed that bleach kits are a good idea. However, they expressed concerns regarding proper instruction for use. Some respondents noted that bleach kits were not adequate to prevent against HCV. A clear and consistent message about the proper use and efficacy of bleach kits to prevent HIV and HCV should be developed and disseminated to IDUs.

In addition to the recommendations based on the information from the assessment, the researchers came to the conclusion that the lack of an adequate IDU surveillance system hinders understanding of and planning for IDUs in Maine in a number of critical health and social services. Therefore, the following recommendation is made:

- **Establish an IDU trend surveillance system.** Accurate statewide information is essential to assessing public health needs of IDUs in Maine. Further examination of existing data collection systems and identification of gaps will help to develop a more comprehensive, standardized method for identifying current issues and tracking IDU trends. Subpopulations of users – such as youth, prison/jail inmates, specific racial and ethnic groups, and rural users – should be identifiable through established surveillance systems.

# APPENDIX A

# COUNTY MAP OF MAINE

**County Map**

of Maine

# APPENDIX B

# DRUG NAMES AND CLASSIFICATIONS

# Drug Names and Classifications

**Prescription Drugs**

**Opioids**: Propoxyphene (Darvocet), methadone (Dolophine), codeine, oxycodone (OxyContin, Tylox), hydrocodone (Vicodin), morphine (sulfate), hydromorphone (Dilaudid), meperidine (Demerol)

**Benzodiazepine - Hypnotics – Benzos**: Alprazolam (Xanax), clonazepam (Klonopin), lorazepam (Ativan), diazepam (Valium)

**Hypnotics – Other:** Diphenhydramine (Benadryl)

**Stimulants**: Ritalin

**Anti-depressants:** Bupropion (Wellbutrin)

**Anesthetic**: Ketamine

**Analgesic**: Nalbuphine (Nubaine)

"Street" Drugs

**Opioids**: Heroin

Cocaine: **Freebase Cocaine, crack Cocaine**

**Cerebral Stimulant/Amphetamine:** Methamphetamine, speed, Amphetamines, Ecstasy MDMA, (psychedelic-amphetamine, synthetic amphetamine analogue)

**Hallicinogens/Psychotropics:** acid/LSD, mushrooms

**Anesthetic**: Special K (Ketamine)

# APPENDIX C

# QUALITATIVE DATA INTERVIEW TOOLS AND CONSENT FORMS

# Consent Form for Individual Interviews

**Title: Injection Drug User Needs Assessment**

**Project Coordinator:** **Jennifer Gunderman-King**
**Maine Bureau of Health**
**State House Station 11**
**157 Capitol Street**
**Augusta, Maine 04333**
**1-800-821-5821**

Federal regulations require that you are informed about research studies. The following information explains the different parts of the study. Writing your initials on the form will mean that this study has been explained to you, and that you agree to participate in it. The process of reading and signing this form is known as informed consent.

## DESCRIPTION:

Thank you for allowing us to interview you. This interview has many purposes: 1) to better understand what injection drug users know about HIV/AIDS and Hepatitis and their risk for getting HIV/AIDS and Hepatitis, 2) to better understand behaviors of injection drug users, 3) to better understand what these individuals think will prevent the spread of HIV and 4) what type of services do injection drug users need to assist them in preventing the spread of HIV/AIDS and Hepatitis. The information you provide today can help us develop better HIV and Hepatitis prevention plans.

I want to tell you about what would be involved if you participate in this interview. Each interview will last about one and a half hours. You will be asked questions about you knowledge of HIV/AIDS, injection drug use and other behaviors related to HIV and Hepatitis, and what you think will prevent you from getting infected with HIV and Hepatitis.

## RISK AND BENEFITS:

Being interviewed has little risk. On risk is that things we talk about could cause you to become upset during or even after the interview. However, interviewers will be able to speak with you after the interview as to where you can go for advice and support.

## COSTS AND PAYMENTS:

There are no costs for you to participate in the research study. You will receive a $30 gift certificate for your participation at the end of the interview.

## ANONYMITY:

We ask that you do not say your last name. This way, it will be impossible for anyone to know how you answered any question. Also, information from the interview will be kept in locked files and only the research team from the Maine Bureau of Health will have access to these files.

**RIGHT TO WITHDRAW:**

Your participation in this study is completely voluntary. You may refuse to take part in it or you may stop participating at anytime, even after putting you initials on this form. There will be no risk in losing or being denied future services for withdrawing from the interview.

If you have any further questions about this research, you can contact the Project Coordinator of the assessment, Jennifer Gunderman-King at 1-800-821-5821.

**********

**SUBJECT CERTIFICATION:**

**VOLUNTARY CONSENT:**

- **I have read the consent form for this study and any questions I had have been answered to my satisfaction.**
- **I understand that I have the right to be provided with the answers to any questions which may come up during the course of the group.**
- **I understand that me being interviewed is voluntary and that I am free to leave at any time.**
- **I agree to participate in this study.**

**INITIALS: _____**

**DATE: _____**

**Injection Drug User Needs Assessment**
**Individual Questionnaire**

## Demographics

Age:

_____ Years old

Gender:

_____ Male
_____ Female

Race/ethnicity:

_____ African American
_____ American Indian
_____ Asian or Pacific Islander
_____ Hispanic
_____ White
_____ Other

Years of education completed:

_____ 8th grade or below
_____ Some high school
_____Completed high school/GED
_____ Some college
_____ 2-year college degree
_____ 4-year college degree
_____ Graduate degree

Income last year:

_____ $0 - $9,999
_____ $10,000 - $19,999
_____ $20,000 - $29,999
_____ $30,000 - $39,999
_____ $40,000 or more

If you are not currently injecting drugs, how long have you been clean?

---

## Questionnaire

1. What kinds of things would you consider to be safe behaviors, or behaviors least likely to put you at risk for HIV?

2. What kinds of things would you consider to be unsafe behaviors, or behaviors most likely to put you at risk for HIV?

3. Do you think you are at risk for HIV??  Why or why not?

4. Where have you received or come into contact with information and prevention services for HIV/AIDS?  What were the services?  What's been good/bad about these services?

5. If you have never received or come in contact with information and prevention services about HIV/AIDS, why do you think that is?  What would you want for HIV information or services?

6. Many prevention services have a hard time reaching IDU's.  Why do you think that is?  What could these services do to reach IDU's?  Where are the best places to reach IDU's?

7. What would you or other IDU's need to use clean needles?  What do you think about needle exchange?  Purchasing needles at pharmacies?  Bleach kits?

8. What drugs are you using and what method do you use to take these drugs?

9. What do you usually inject drugs with?

10. How did/do you get needles?

11. Is it easy or hard to for you to get clean needles?

12. What did/do you do with syringes after you use them?

13. Do/did you share syringes? Why or why not?

14. Do/did you share your works?

15. Do/did you inject yourself?

16. What do you or other IDU's who want to stop using need to stop? Methadone programs? Treatment or recovery centers?

17. Are you concerened about getting HIV/AIDS and/or Hepatitis C?

18. Have you ever been tested for HIV?

19. Have you ever been tested for Hepatitis C?

20. Have you ever gotten sick or hurt from injecting drugs? Did you see a doctor or go to the hospital?

21. Do you have a regular doctor that you visit?

22. Any last comments? Suggestions for improving our outreach efforts to folks in the IDU community?

**Injection Drug User Needs Assessment**
**Penobscot County Jail Questionnaire**

1. What are ways you can stay safe from HEP/HIV?

2. What are unsafe behaviors?

3. How many of you have gotten HEP/HIV information?

4. Where did you get the information?

5. Is the information you are getting helpful?

6. How would you make services better?

7. What would make it easier to access?

8. What experiences have you had a pharmacies?

9. What do you think of the Methadone clinic?

10. What's going on outside of here re: needle usage?

11. Differences now compared to 10 years ago?

12. Are younger people using?

13. What about Oxy's?

14. HEP – C

15. Do you feel you need more HEP/HIV information

16. What are people using?

17. Scenario: What do people need to keep them clean?

18. When you leave what do you need for services/help? Parole officers are they any help?

**Injection Drug User Needs Assessment**

**Portland Public Health Questionnaire**

1. What kind of things would you consider to be "safe" behaviors or behaviors least likely to put you at risk for HIV?

2. What kind of things do you consider to be "unsafe" behaviors or behaviors most likely to put you at risk for HIV?

3. Do you think you are at risk for HIV?

4. Where have you received or come in contact with information and prevention services about HIV/AIDS?

   * What are these services?

   * Have any of these services had an effect on your behaviors and/or attitudes about HIV?

   * Can you think of anything good/effective about these services?

   * Could these services been better in any other way?

   * What do you like about these services?

5. If you have never received or come in contact with information and prevention services about HIV, why do you think that is?

   * What would you want from HIV information?

   * What would you want for HIV services?

6. Many HIV prevention services have a hard time reaching IDU's, why do you think that is?

   * What could these services do to reach other IDU's?

* Where is the best place to reach IDU's for HIV prevention?

7. What would you or other IDU's need to use clean needles?

* What do you think about needle exchange?

* What do you think about pharmacies selling needles?

* Do you need bleach kits?

**Injection Drug User Needs Assessment**
**HIV/AIDS Service Provider Questionnaire**

Name:_____ Title: _____

Organization:_____ Phone: _____

Fax:_____ Email:_____

Summary of services your organization provides to injection drug users:

Based on your experiences, please comment on the following characteristics.
Demographics of injection Drug Use in Maine:

- Drugs: What drugs are being injected? Any changes over the past years?

- Age: Is one age group injecting more than others? What are the differences in injecting practices among age groups? Any changes over the past years?

- Gender: Is one gender injecting more than others? What are some differences in injecting practices among genders? Any changes over the past years?

- Ethnicity: Is one group injecting more than others? What are some differences in injecting practices ethnic groups? Any changes over the past years?

- Occupation: Are you seeing any correlation between occupation and injection use? Any changes over the past years?

- Socioeconomic status: Are you seeing any correlation between socioeconomic status and injection drug use? Any changes over the past years?

- Location: Generally speaking, where are they shooting? What is a typical shooting gallery in Maine?

What are some barriers that your organization experiences when trying to access IDUs or when providing services to IDUs concerning HIV prevention?

What are you organization experiences when trying to access IDUs or when providing services to IDUs concerning HIV prevention?

Would you and/or your agency be willing to assist the Maine Bureau of Health in collecting information from IDUs for the needs assessment including conducting interviews, assisting with focus groups, etc.?

Additional Comments:  Please express other experiences/observations that you feel would be imperative to the needs assessment.

**Injection Drug Use Needs Assessment**
**Key Informant Questionnaire**

Specific Discussion Topic: Injection Drug Use in Maine and related issues based on key informant's experiences.

1. In what capacity do you work with injection drug users and/or the issue of injection drug use?

2. What trends do you see occurring with injection drug use?

   Who is injecting?

   What are they injecting?

   Where are they injecting (geographical locations)?

3. What changes have you seen in the past five years with injection drug use?

   Increasing or decreasing?

   Demographical changes?

4. What are the greatest obstacles for injection drug users to get clean needles/treatment/counseling?

*For the former IDU and Methadone clinic caseworker key informants, the following question 4 was asked:*

4. What are some needs of an injection drug or the injection drug population?

5. What can be done to eliminate these obstacles?

For the former IDU and methadone clinic caseworker, the following alternate question 5 was asked:

5. Is HIV or Hepatitis important to injection drug users?

6. We will be doing focus groups with injection drug users:
    1. Need help accessing them. Do you know of an outlet to recruit focus group participants?

    2. What should we be asking them?

# APPENDIX D

# INDIVIDUAL IDU INTERVIEW RESPONSES

# INDIVIDUAL IDU INTERVIEW RESPONSES

The raw data to the 22-question interview form are available for 40 respondents. These data are presented below. Not all of the respondents answered all 22 of the questions. Some of the questions lent themselves to multiple responses from one or more individuals. Therefore, the number of total responses will vary from question to question. (This will be indicated by an [*] following the total response calculation for the individual questions.) Also, the following data include responses from a group of eight individuals who were convened to answer this questionnaire. It is possible that their responses were influenced by group discussions, which may have biased some of the response categories and total responses.

## Individual Interview Results

**1. What kinds of things would you consider to be "safe" behaviors or behaviors least likely to put you at risk for HIV?**

| **"Safe" Behaviors** (***as defined by the respondent***) | Number of Times Mentioned |
|---|---|
| Clean needles/works | 21 |
| Condoms and safe sex | 21 |
| Abstinence from drugs | 9 |
| Abstinence from sex | 8 |
| Limit sex partners | 8 |
| Not injecting (snorting instead of shooting) | 5 |
| Not sharing needles/works | 5 |
| Limit drug use | 1 |
| Other/unclear | 12 |
| **TOTAL** | 88* |

**2. What kinds of things do you consider to be "unsafe" behaviors, or behaviors most likely to put you at risk for HIV?**

| **"Unsafe" Behaviors** (***as defined by the respondent***) | Number of Times Mentioned |
|---|---|
| Unprotected sex (not using condoms) | 24 |
| Sharing needles/works | 18 |
| Using dirty needles/works | 11 |
| Drug use | 7 |
| Having sex when high | 6 |
| Multiple sex partners | 3 |
| Sex | 3 |
| Shooting instead of snorting | 2 |
| Other/unclear | 2 |
| **TOTAL** | 76* |

**3. Do you think you are at risk for HIV? Why/why not?**

| **Risk Status** (*as defined by the respondent*) | Number of Times Mentioned | Percent of Total Responses |
|---|---|---|
| No | 16 | 55% |
| No risky behaviors (8) | | |
| In recovery (5) | | |
| Not while incarcerated (3) | | |
| Yes | 13 | 45% |
| Risky behaviors (7) | | |
| Sometimes (6) | | |
| **TOTAL** | 29* | 100% |

Most of the respondents seemed to have a good understanding of which behaviors were more likely to put them at risk for HIV and other blood-borne diseases. However, several of the respondents noted that although they were aware of the more risky behaviors associated with IDU, when they were high, being safe was not a top priority.

**4. Where have you received or come in contact with information and prevention services about HIV/AIDS?**

| **Source of HIV/AIDS Prevention Services/Information** | Number of Times Mentioned |
|---|---|
| Media | 19 |
| HIV/AIDS service organizations | 10 |
| Schools | 9 |
| Needle exchange | 8 |
| Methadone clinic | 7 |
| Jail | 6 |
| Substance abuse treatment center/DETOX | 5 |
| Other clinics | 3 |
| Other | 4 |
| **TOTAL** | 71* |

**What were these services? Have any of these services had an effect on your behaviors or attitudes about HIV? Can you think of anything that was good/effective about these services? Could these services have been better in any other way? What didn't you like about these services?**

The participants reported receiving prevention information, testing services, clean needles, bleach kits, and condoms from the above sources. Most of the respondents made positive comments regarding available services and believed that the prevention information they received had reduced their risk of disease exposure. Several respondents noted that prevention information is most helpful and effective when it comes from peer educators−former users and young people who know the lingo. This is more effective than just receiving written information. Several interviewees stressed the importance of keeping the police out of the intervention process. Users fear law enforcement, and this sometimes prevents them from seeking medical assistance during crisis situations (i.e., during a potential overdose incident).

**5. If you have never received or come in contact with information and prevention services about HIV/AIDS, why do you think that is? – What would you want for HIV information? What would you want for HIV services?**

All of the respondents had received HIV prevention information or services. The number of responses to the follow-up questions was limited. To improve upon existing services, three respondents suggested that there be more of a focus on youth and school-based interventions. Two interviewees suggested an increase in promotion of the needle exchange. It was also suggested that there be more needle exchange programs and that services be made available at night. Two respondents supported more testing sites, and another suggested an increase in counseling services. One interviewee thought there should be more educational services in methadone clinics, recovery centers, and jails, and another supported increased condom availability. A suggestion to remove law enforcement from intervention services was made in one interview. A respondent mentioned each case management services and assistance in locating a physician, and there was one interviewee who suggested that new statistics would be helpful.

**6. Many HIV prevention services have a hard time reaching IDUs. Why do you think that is? What could these services do to reach IDUs? Where are the best places to reach IDUs for HIV prevention?**

| **Barriers** | Number Of Times Mentioned | **Best Ways** | Number Of Times Mentioned | **Best Places** | Number Of Times Mentioned |
|---|---|---|---|---|---|
| Trust | 13 | General outreach | 10 | Substance abuse treatment centers/Detox | 12 |
| Fear of law | 10 | IDU-to-IDU outreach | 6 | Methadone clinics | 11 |
| Privacy | 8 | Literature | 1 | Jails/prison | 10 |
| Fear | 1 | Vouchers | 1 | Shelters/soup kitchens | 2 |
| | | | | Streets (Grant Street, Park Avenue) | 2 |
| | | | | Schools/parent educ. | 2 |
| | | | | Media/Internet | 2 |
| | | | | Clubs, malls, etc. | 2 |
| | | | | Hospital | 1 |
| **TOTAL** | 32* | | 18* | | 44* |

Many of the interviewees stressed the isolation and privacy associated with IDU. Most users do not want others outside of their subculture to know about their addiction. They conceal their use and stay within the circle of friends and family that use with them, trusting no one outside of their close-knit community. Fear of the law is an additional pressure to hide IDU addiction and further affects the user's ability to trust intervention services. The respondents emphasized the need for outreach workers to slowly develop a sense of trust with users – often times, this is most effective when the prevention worker is a former user or someone with a very good knowledge of IDU, its lingo, and the cultural norms of the group.

**7. What would you or other IDUs need to use clean needles?** ***(Note: The respondents answered this question by responding to the following multiple parts.)***

**What do you think about needle exchange?**

| **Needle Exchange** | Percent of Total Responses |
|---|---|
| Pro (26) | 93% |
| Con (2) | 7% |
| **TOTAL (28)*** | 100% |

Five respondents suggested there be longer hours for the needle exchange programs, and five said that there need to be more needle exchange programs. Three respondents supported mobile needle exchange, and there was a suggestion to provide needle exchange in the hospital and at physicians' offices.

**What do you think of pharmacies selling needles?**

| **Pharmacies** | Percent of Total Responses |
|---|---|
| Pro (17) | 63% |
| Con (10) | 37% |
| **TOTAL (27)*** | 100% |

Although many of the respondents supported the idea of purchasing needles through pharmacies, 14 interviewees noted that there is a great deal of discrimination among pharmacists. Most who were not in favor of pharmacies as a source for clean needles felt this way because of prior negative experiences, inconsistent treatment, and fear of being asked for identification.

**Do you need bleach kits? ****

| **Bleach Kits** | Percent of Total Responses |
|---|---|
| Pro (20) | 71% |
| Con (8) | 29% |
| **TOTAL (28)*** | 100% |

*** Most respondents answered this question in a pro or con fashion versus "Do you need bleach kits?".*

Although most of those interviewed thought bleach kits were a good idea, there were cautionary statements regarding proper instruction, and four interviewees noted that bleach kits might provide users with a false sense of safety. Three respondents noted that bleach kits were not adequate to protect against hepatitis C and, therefore, were not in favor of their use. Many suggested bleach kits only be viewed as a safety procedure of last resort.

**8. What kinds of drugs are you currently using and what method do you use to take these drugs?**

| **Drugs Mentioned with Injection Specified** (*as categorized/named by the respondent*) | Number of Times Mentioned |
|---|---|
| Heroin | 17 |
| OxyContin | 13 |
| Dilaudid | 8 |
| Percocet | 7 |
| Vicodin | 7 |
| Cocaine | 4 |
| Ritalin | 3 |
| Crystal Meth | 2 |
| Klonopin | 2 |
| Morphine | 2 |
| ***Mentioned Once*:** | 7 |
| Speed, Ecstasy, Benadryl, Xanax, Demerol, Methadone, Nubain | |
| **TOTAL** | 72* |

There were 64 additional responses to this question listing drugs that were not injected or the method of use was not specified in the response. The range of drugs mentioned included everything from crack/cocaine to cigarettes, alcohol, keyboard cleaner, and "everything." Four of those interviewed answered that they are clean and sober. Several of the interviewees talked about the allure of the needle and the thrill of the injection ritual (i.e., mixing the drugs, cooking them, and tying the tourniquet).

**9. Who did/do you inject drugs with?**

| People With Whom You Inject | Number of Times Mentioned |
|---|---|
| Friends | 25 |
| Partner/spouse | 15 |
| Alone | 10 |
| Family members | 2 |
| Other (dealer, other sex workers) | 2 |
| **TOTAL** | 54* |

Three of the respondents stated that they never inject alone, and four said that they never or seldom inject with strangers. Several of those who responded that they inject alone did not inject alone all of the time and were aware of the risk of overdosing when by themselves.

**10. How did/do you get needles?**

| Needle Sources | Number of Times Mentioned |
|---|---|
| Pharmacies | 15 |
| Friends | 12 |
| Needle exchange | 11 |
| Diabetic friends/family members | 6 |
| Other (dealers, Wal-mart, home-made) | 3 |
| **TOTAL** | 47* |

**11. Is it hard or easy for you to get clean needles?**

| Ability to Get Clean Needles | Number of Times Mentioned | Percent of Total Responses |
|---|---|---|
| Easy | 14 | 56% |
| Hard | 11 | 44% |
| **TOTAL** | 25* | 100% |

Nine of the interviewees mentioned the "hit or miss" experience of purchasing needles through pharmacies – some require identification, some ask questions, some "hassle" the buyer, etc. One respondent mentioned that it is hard to get clean needles if you are already high, and another said that it is hard to get them in jail. Two of those interviewed recommended that the Portland Needle Exchange (PNE) extend its hours.

## 12. What do/did you do with syringes after you use them?

| Method of Syringe Disposal | Number of Times Mentioned |
|---|---|
| Trash – with solid container | 15 |
| Trash – no solid container | 10 |
| Solid container through PNE | 9 |
| Toilet | 6 |
| **TOTAL** | 40* |

Many of the respondents mentioned more than one type of disposal. What method they utilized often depended upon the situation and the environment in which they were getting high. Two of the respondents said that the fear of being caught with needles often prevents them from taking the time to dispose of them properly.

### 13. Do/did you share syringes after you use them?

| Share Syringes After Use | Number of Times Mentioned | Percent of Total Responses |
|---|---|---|
| Yes | 30 | 81% |
| Do share used syringes (24) | | |
| Did share used syringes (6) | | |
| No – Never do/did share used syringes | 7 | 19% |
| **TOTAL** | 37* | 100% |

Those who responded "Yes" to sharing may not have shared all of the time, but were inclined to share syringes when high, with friends or partners, or when new syringes were unavailable (even though most of the respondents knew of the risks associated with this behavior). Of the six respondents who said that they did share used syringes in the past, four did not currently share syringes. Two of the six who said they did share in the past noted that the HIV/hepatitis C prevention information they received during the needs assessment interview had convinced them that they should not share in the future.

### 14. Do/did you share your works?

| Share Works After Use | Number of Times Mentioned | Percent of Total Responses |
|---|---|---|
| Yes | 26 | 90% |
| Do share used works (19) | | |
| Did share used works (7) | | |
| No– Never do/did share used works | 3 | 10% |
| **TOTAL** | 29* | 100% |

As with sharing syringes, respondents noted that they did not share their works all of the time but were more inclined to share when high, or with friends or partners.

**15. Do/did you inject yourself? Does/did someone else inject you?**

| Method of Injection | Number of Times Mentioned | Percent of Total Responses |
|---|---|---|
| Inject myself | 34 | 92% |
| Injected by someone else | 3 | 8% |
| **TOTAL** | 37* | 100% |

Of those who reported injecting themselves, 16 report that someone else injected them at first (i.e., until they learned how and were comfortable self-injecting). Ten of the respondents said that they often inject others when getting high in a group.

**16. What do you or other IDUs who want to stop using need to stop? (*See table below.*) Methadone programs? Treatment recovery centers? (*See summary below.*)**

| Services/Support Required to Stop | Number of Times Mentioned |
|---|---|
| Supportive environment | 16 |
| Treatment/rehab services | 15 |
| Methadone | 10 |
| Willpower | 8 |
| Detoxification | 2 |
| Other | 4 |
| **TOTAL** | 55* |

When respondents defined a "supportive environment," it included having adequate family support, social support, and the unbiased support of the medical community. A few of the respondents noted that to quit IDU, they would need to separate from the individuals with whom they are using and redefine their social structure.

When respondents listed treatment or rehabilitation services they believed to be effective, they included Narcotics Anonymous, case management, and counseling services.

*Methadone Programs:* Fourteen of the respondents felt that methadone is "just another drug" and did not consider it a valid long-term recovery option. A few of the respondents said that there are risks associated with methadone use, such as driving after dosing, receiving too high a dose, and users selling their doses on the streets. One suggestion was made for more methadone clinic locations and for home treatments.

*Treatment Recovery Centers:* Nine of the respondents made positive comments about treatment recovery programs, and this type of intervention was generally seen as a better long-term recovery solution.

**17. Are you concerned about getting HIV/AIDS and/or hepatitis?**

| Concerned about HIV/AIDS and/or Hepatitis | Number of Responses | Percent of Total Responses |
|---|---|---|
| Yes | 21 | 72% |
| No | 8 | 28% |
| **TOTAL** | 29* | 100% |

**18. Have you ever been tested for HIV?**

| Tested for HIV | Number of Responses | Percent of Total Responses |
|---|---|---|
| YES | 32 | 94% |
| NO | 2 | 6% |
| **TOTAL** | 34* | 100% |

**How long ago? Do you know your HIV status? Would you recommend other IDUs you know to get tested?**

Responses regarding how long ago the interviewee had been tested for HIV ranged from "yesterday" to more than 10 years ago, with the majority having been tested within the last three to six months. Those who had been tested (and the results were available to them at the time of the interview) knew their status. All of the responses regarding whether or not they would recommend HIV testing were in favor of testing. Many spoke of the early detection, treatment, and prevention opportunities of knowing one's HIV status. One of the respondents who reported never having been tested said that the fear of knowing his/her status was the primary reason for not testing.

**19. Have you ever been tested for hepatitis?**

| Tested for Hepatitis | Number of Responses | Percent of Total Responses |
|---|---|---|
| Yes | 18 | 53% |
| No | 16 | 47% |
| **TOTAL** | 34* | 100% |

**How long ago? Do you know if it was hepatitis B or C? Do you know if you have hepatitis? Would you recommend other IDUs you know to get tested?**

Responses regarding how long ago the interviewee had been tested for hepatitis ranged from one month to two years ago, with the majority having been tested within the past year. Of those who had been tested for hepatitis (18), only 3 mentioned that they had been tested for hepatitis B; 1 of the interviewees had been tested for both. Eight of the respondents were positive for hepatitis C, 1 was positive for hepatitis B, and 1 respondent was positive but did not specify the type of hepatitis. All those tested knew their status and recommended that other IDUs get tested to prevent transmission and to address their own health care needs.

**20. Have you ever gotten hurt or sick from injecting drugs? Did you see a doctor for this? Go to the hospital?**

| Hurt/Sick from Injecting Drugs | Number of Responses | Percent of Total Responses |
|---|---|---|
| Yes | 30 | 81% |
| Saw a doctor (3) | | |
| Went to the hospital - includes detox (8) | | |
| No | 7 | 19% |
| **TOTAL** | 37* | 100% |

Note: Being "hurt or sick" included responses from users who had experienced cotton fever, endocarditis, and abscesses, as well as those with HIV, hepatitis, and those who had been through life-threatening overdoses. Not all of those who responded "Yes" to this question answered the follow-up question specifying whether or not they had seen a doctor or gone to the hospital. Also, respondents may have been

sick on more than one occasion, and may have visited a hospital *and* seen a doctor. Consequently, it is not possible to make conclusions about access to services based on the responses.

### 21. Do you have a regular doctor?

| **Regular Doctor** | Number of Responses | Percent of Total Responses |
|---|---|---|
| Yes | 23 | 66% |
| No | 12 | 34% |
| **TOTAL** | 35* | 100% |

### Is it a walk-in clinic or a doctor's office?

Sixteen of the respondents provided information regarding the location of their regular doctor. Of those, 11 said they receive services in an office setting; 4 go to a clinic to see their doctor, and 1 respondent uses the emergency room for medical care.

### Is he/she aware of you injecting drugs?

There were 20 responses to the question about whether or not the provider was aware of the participant's IDU. Of those who answered this question, 14 said that their provider did have knowledge of their drug addiction.

### How do you pay for your health care?

Of the 25 individuals who answered this part of the question, almost half (12) used Medicaid to pay for their health care services. Six of the respondents had private health insurance benefits and 6 were uninsured. One respondent received Medicare benefits to cover health care costs.

### 22. What kind of drugs have you used in the past?

| **Types of Drugs Used in the Past** (*as categorized/named by the respondent*) | Number of Times Mentioned |
|---|---|
| Marijuana | 15 |
| Alcohol | 14 |
| Heroin | 12 |
| Cocaine | 10 |
| OxyContin | 5 |
| Benzos | 4 |
| Acid | 3 |
| Cigarettes | 3 |
| Crystal meth | 3 |
| Speed | 3 |
| Ecstasy | 2 |
| Methadone | 2 |
| Methamphetamines | 2 |
| Opiates | 2 |
| ***Mentioned Once:*** | 13 |
| Mushrooms, Darvocet, Ritalin, Ativan, Tylox, Crack/cocaine, Hydrocodone, Morphine, Special K, Wellbutrin, Percocet, Xanax, Klonopin, | |
| ***Other*** – includes "everything," "stimulants," "most narcotics" | 10 |
| **TOTAL** | 103* |

# APPENDIX E

## PORTLAND PUBLIC HEALTH GROUP INTERVIEW RESPONSES

# PORTLAND PUBLIC HEALTH
# GROUP INTERVIEW RESPONSES

## Portland Public Health Group Interview Results

### 1. *What kinds of things would you consider "safe" behaviors or behaviors least likely to put you at risk for HIV?*

Abstinence
Not sharing needles
Using clean needles and works
Taking care of yourself

The group discussed the potential benefits of legalizing more drugs than just tobacco and alcohol, and legitimizing needle possession (needle-dispensing machines were proposed). Fear of being arrested discourages people from carrying clean needles, and the social stigma associated with IDU affects user behavior.

### 2. *What kinds of things do you consider to be "unsafe" behaviors or behaviors most likely to put you at risk for HIV?*

Improper bleaching (of needles)
Sharing needles and works
Unsafe sex – not using condoms
Desperation for next "fix" (adversely affects decision-making ability)
Attitude of futility ("I must have it by now, anyway.")
Not taking care of yourself (increases susceptibility to HIV)

### 3. *Do you think you are at risk for HIV?*

The group consensus was that everybody is at risk of contracting HIV all the time. (Note: One group member was identified as being HIV positive.) The participants stated that in certain situations, prevention strategies do not occur to them – i.e., when "dope sick" or high, or at night when clean supplies are not available. The group talked about the benefits of planning ahead and getting needles *before* they need them.

### 4. *Where have you received or come in contact with information and prevention services about HIV/AIDS?*

Methadone clinic (Discovery House)
Portland Public Health
Outreach Workers
Jail (limited information available)
CAP Quality Care

Not all participants were satisfied with some of the services.

### 4a. *What were these services?*

Information – safe sex messages
Condoms
Clean needles/works

### 4b. *Have any of these services had an effect on your behaviors and/or attitudes about HIV?*

Better utilization of the needle exchange
Interest in becoming a peer educator

Better understanding of HIV

### 4c. *Can you think of anything good/effective about these services?*

*Note: Responses pertained to services received at Portland Public Health.*

Providers who know the lingo
Ex-junkies available
Harm-reduction based
Not preachy about getting off drugs, but available if you are ready

### 4d. *Could these services have been better in any other way?*

More treatment options –other than methadone
Detox instead of methadone
Provide information on out-of-state resources (generally perceived by the group as more humane)

The group expressed concern about young kids being steered to methadone maintenance when what they really want is detox.

### 4e. *What didn't you like about these services?*

Jail system services too infrequent
Methadone clinics treat people very badly

### 5. *If you have never received or come into contact with information and prevention services about HIV, why do you think that is?*

All members of the group had received information and prevention services.

### 5a. *What would you want for HIV information?*

Everything from A to Z
How it is transmitted and prevented
Compassionate presentation (vs. "scared straight" style)
Harm-reduction based
Youth-centered (have school groups see the services at India street and the needle exchange)

### 5b. *What would you want for HIV services?*

Affordable health care
Affordable prescriptions
Affordable diagnosis, care, and treatment of hepatitis C (as well as prevention information)

### 6. *Some HIV prevention services have a hard time reaching IDUs. Why do you think that is?*

Find out from users where to do outreach
Peer educators would be well received

### 6a. *What could these services do to reach other IDUs?*

Build relationships with *known* IDUs and develop peer education opportunities
Focus on harm reduction
Use known IDUs to find other users

### 6b. *Where is the best place to reach IDUs for HIV prevention?*

Homeless shelters
Old Port area
Treatment facilities
Methadone clinics
Everywhere

The group noted that many IDUs do not want to be associated with the stigmatized group of IDUs and don't identify as users themselves. These individuals are more reluctant to utilize social services and therefore are not receiving prevention information.

### 7. *What would you or other IDUs need to use clean needles?*

No fear of being arrested for carrying clean works
Needle exchange works well (to access information and to dispose of used needles)
Less discrepancy among pharmacists who will or will not sell needles (unable to depend on the law)
Pharmacists who are required to sell needles to anyone, no identification necessary

### 7a. *What do you think about the needle exchange?*

All of the participants had used the needle exchange at some time. They were enthusiastic about the services and said that more were needed. They wished that more IDUs could plan ahead and not get into desperate situations.

### 7b. *What do you think about pharmacies selling needles?*

Good idea that should be expanded
Many pharmacists are condescending and inconsistent about selling syringes
No education is provided
Allowing the pharmacists discretion to sell or not may be denying needles to those who need them most

### 7c. *Do you need bleach kits?*

There was some discussion among the group regarding conflicting information about proper bleaching for HIV and hepatitis C prevention. Participants could not say for sure what was the correct procedure and were unclear about different recommendations for different blood-borne diseases. They felt that bleach kits were a good idea if adequate information regarding proper use was included on the kit.

# APPENDIX F

# SERVICE PROVIDER SURVEY RESPONSES

# SERVICE PROVIDER SURVEY RESPONSES

## Service Provider Survey Results

### *1. DRUGS:*

***What drugs are being injected?***

Heroin (13)
OxyContin (11)
Cocaine (8)
Benadryl (7)
Speed (3)
Crack/cocaine (2)
Methamphetamines (2)
Crystal meth (2)
Dilaudid (2)
Crack
Steroids
Neurontin
Vitamins
Hormones
Percodan
Morphine
Amphetamines
Other prescription drugs

***Any changes over the past years?***

**Increased usage:** OxyContin (3), Methamphetamines, Heroin, Benadryl
**Decreased usage:** Crack/cocaine (2)
**New:** OxyContin (2)

### *2. AGE:*

***Is one age group injecting more than others?***

Middle-aged men (2)
18-year-olds in jails
20- to 35-year-olds
18- to 25-year olds
15 to mid-50s
20- to 50-year-olds
16- to 25-year-olds in Belfast
18- to 45-year- olds in fishing communities

***What are some differences in injecting practices among age groups?***

Younger people using OxyContin (3)
Older people using heroin (2)
Younger using coke, OxyContin, and Benadryl
Younger people utilize Portland Needle Exchange
Fishermen using more heroin
Younger users are unaware of safe shooting practices
Older users are aware of safe shooting practices, but don't always use them

***Any changes over the past years?***

Growth in under-age-24 population and high school populations (3)
Age getting younger all the time (3)

### *3. GENDER:*

***Is one gender injecting more than others?***

More males (6)
No difference (4)
Incarcerated males
Non-incarcerated females
Female population small, but fast growing
See more women (family planning center)

***What are some differences in injecting practices among genders?***

Females tend to inject with sexual partner
Fewer women are hard-core users, more recreational

***Any changes over the past years?***

More women in the 20- to 35-year-old range

## *4. ETHNICITY:*

***Is one ethnic group injecting more than others?***

No – reflects the demographic (7)
Mostly whites (3)
Mostly white males (2)
Native American women

***What are some differences in injecting practices among ethnic groups?***
Hispanic men seem to shoot together with the same guys

***Any changes over the past years?***
No differences now, but there were in the past

## *5. OCCUPATION:*

***Are you seeing any correlation between occupation and injection use?***

Clam diggers and fishermen (5)
Unemployed (4)
No (4)
Blue-collar workers (2)
Secondhand information about fishermen
Do not collect this information

***Any changes over the past years?***

More homeless and unemployed

## *6. SOCIOECONOMIC STATUS:*

***Are you seeing any correlation between socioeconomic status and injection use?***

No (4)
Poor/unemployed (4)
Do not collect this information
Young, bored, wealthy teenage boys
Underemployed educated
Low-income and low-educated individuals in shore communities

## *7. LOCATION:*

***Generally speaking, where are they shooting?***

Homes (12)
Prison/jail (3)
Bars (3)
Cars and trucks (2)
Fishing, lobster boats (2)
Bathrooms
Restaurants
Behind schools and shops
Parties
Dorm rooms
Woods
Cemeteries
Everywhere
Hunting and ice fishing huts

***What is a typical shooting gallery in Maine?***

A rotation among homes

## *8. BARRIERS:*

***What are some barriers that your organization experiences when trying to access IDUs or when providing services to IDUs concerning HIV prevention?***

Gaining trust (6)
Funding (5)
Fear of incarceration (4)
Identifying IDUs
Transportation to needle exchange

Access to IDUs (3)
Time (2)
Cooperation of local/state police (2)
Cooperation of social service agencies (2)
Jail/prison access
Rural nature of the state
Cooperation and knowledge of medical professionals
Societal stigma
Denial of the problem
Personal safety

## *9. ORGANIZATIONAL NEEDS:*

***What are your organization's needs for accessing and working with IDUs concerning HIV prevention?***

Funds to establish and maintain networks of care (5)
Funds to train staff (4)
Mechanisms for agency collaboration (2)
Support from public officials
Transportation
Peer educators
Methadone clinics
Funds for needle exchange
Time
Reduce stigma associated with IDU

## *10. ADDITIONAL COMMENTS:*

***Please express other experiences/observations that you feel would be imperative to the needs assessment.***

Public awareness is important to reduce the IDU stigma and improve access to IDUs
Need more state support for this high-risk population
Include steroid users, vitamin users, and hormone users in the IDU population
Be proactive – trends (types of drugs injected) from other states will eventually reach Maine
Learn from other states